

PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

2005

Prepared by the Legislative Council Service Staff
Pamela Ray, Staff Attorney
Lisa Barsumian, Researcher
Tim Crawford, Records Officer

PUBLIC EMPLOYEE
BENEFITS OVERSIGHT SUBCOMMITTEE
for
2005

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PUBLIC EMPLOYEE
BENEFITS OVERSIGHT SUBCOMMITTEE

Section 1

2005 ANNUAL SUMMARY

**PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
OF THE LEGISLATIVE COUNCIL
2005 ANNUAL SUMMARY**

Representative Ben Lujan, Chair
Senator Lidio G. Rainaldi, Vice Chair

The Public Employee Benefits Oversight Subcommittee of the Legislative Council met five times in 2005. All meetings were held in Santa Fe. The scope of inquiry of the subcommittee was restricted to employee benefit plans. Retirement programs were reviewed by the State Permanent Fund Task Force, another interim committee. The medical benefit plans for the State of New Mexico, the Public School Insurance Authority (PSIA), Albuquerque Public Schools (APS) and the Retiree Health Care Authority (RHCA) were reviewed in detail. Medical benefit plans offered by the University of New Mexico and New Mexico State University were also reviewed. The New Mexico Municipal League, which provides benefit coverage for many of the small towns in New Mexico, also presented details of its benefit package to the subcommittee.

The interim was used in large part to provide information to subcommittee members on the similarities and differences among the various plans, how the employee populations differed among plans, the actuarial soundness of the reserves and costs of the plans.

Populations Covered — Self-Insured Plans

The Risk Management Division (RMD) of the General Services Department, the PSIA, APS and the RHCA offer group health care benefits that are self-insured. This means the risk of not having the money to pay the claims if the claims cost spike to a level that exceeds the amount of money brought in by premiums and must be covered by the reserves of the program, not by an insurance company. Medical, dental and vision care are self-insured. RMD, PSIA and RHCA all have reserve funds that are considered actuarially sound. APS is short on its reserves and is raising premiums to allow the reserves to increase over the next few years. APS has reserves that are four percent of claims, but is moving to have reserves of nine percent.

Administration of the four agencies is done in two phases: in-house administration and administrative-services-only (ASO) administration. In-house administration involves identifying the employers, employee members and the dependents qualified for coverage; fielding questions and gathering complaints; paying for claims; collecting premiums; devising financially sound plans; and maintaining and investing reserve funds. The actual administration of the package is provided by an ASO contractor. There are three ASO contractors that administer the medical programs for the four agencies: Blue Cross/Blue Shield New Mexico (BC/BS), Presbyterian (Pres) and Cigna. The legislature created the Interagency Benefits Advisory Committee (IBAC), which includes RMD, PSIA, APS and RHCA as members. The purpose of IBAC is to negotiate ASO contracts as a group to bring the greatest clout of all four agencies to bear on the negotiations to keep the costs of administering the program as low as is feasible. Each agency has the authority to develop a plan design and to request that it be administered by the ASO contractors. Each agency has developed one to three different plan designs for each ASO with which it contracts. The various plans allow employees to choose the type of plan that fits their

budget best or that satisfies the medical practitioner needs of the employee. The reasons given for the diversity of plan designs are: the age of the members, the location of the employees, the salary of the employees and preferences of doctors. For example, the retiree health care plan has to use different strategies to contain costs than does APS because of the age of its member population. In addition, APS has a confined service area in Albuquerque, so the cost of its insurance for its relatively young population is thought to be less than for programs that must ensure that services are available throughout the state. RMD and PSIA have about the same employee member size and are statewide programs.

Program Comparison

RMD offers three medical plans, one by each of the ASO providers. PSIA offers BC/BS and Pres, and it has two plan levels for each ASO. APS offers Pres and Cigna, each at one level. They are considering offering a very basic, less expensive alternative plan also at some point in the future; hopefully, this will encourage low-income employees to enroll in the more basic plan and increase the percentage of low-income employees who are covered by insurance. RHCA offers plans from two ASO carriers, BC/BS and Pres, each with three possible levels of quality and richness of services, although the premiums for both plans seem to be the same at each level of service. RHCA also offers Medicare supplemental insurance offered by BC/BS, Lovelace Senior Plans or Pres Senior Plans. The subcommittee did not closely examine the differences between plan details, such as what makes a plan a richer plan and why some rich plans cost the same as more austere plans. The subcommittee looked at other more global comparison factors, such as rules for open enrollment and preexisting condition waiting periods. RMD and PSIA have annual open enrollment/switch enrollment periods. APS has four years between open enrollment. New employees can enroll when they begin work, but if an employee opts not to enroll when first employed, the employee must show a qualifying event, such as the insurance by which the employee was covered through the employee's spouse was canceled through no fault of the employee. RHCA has open enrollment periods that last 30 days following an employee's retirement or involuntary loss of other medical coverage. Switch enrollment periods are held annually by RHCA. Medicare supplemental open enrollments are held annually from January through March.

This year provided the subcommittee with a great deal of background relating to benefit plans of the four IBAC agencies and how they compare. It is still necessary that the subcommittee look more specifically at how the agencies can find greater savings and work together in more ways to provide those savings.

Legislative Proposals

Six legislative initiatives were endorsed by the subcommittee.

1. Draft #1 requires the Group Benefits Committee to have oversight functions and advise RMD on many aspects of administering the group benefits plans for state employees and other participating employers, and to meet no fewer than four times per year. The draft bill amends Section 10-7B-3 NMSA 1978.

2. Draft #2 amends the Retiree Health Care Act, Section 10-7C-4 NMSA 1978, to include the following in the definitions:

- increase the maximum required age of providing coverage for an unmarried dependent to up to 25 years, and correspond with the requirements of the Health Care Purchasing Act, which was adopted in 2003; and
- allow dependents insured by a member employee's plan to also be insured by the retiree health care plan.

3. Draft #3 amends the senior prescription drug program to reduce the age qualification so that the general public can use the program and to change the name to the discount prescription drug program. The draft amends Section 10-7C-17 through 10-7C-19 NMSA 1978.

4. Draft #4 amends the Public School Insurance Authority Act to require APS to either join PSIA by December 1, 2007 or show that it offers an equivalent health benefits package.

5. Draft #5 amends the Public School Insurance Authority Act to change the employer contribution minimums and maximums. The amount required to be contributed for employees by the employer is as follows: those earning less than \$20,000 is increased to 80 percent; those earning up to \$25,000 is increased to 75 percent; those earning up to \$30,000 is increased to 70 percent; those earning between \$30,000 and \$100,000 stays at 60 percent; and for employees earning salaries of \$100,000 or more becomes 50 percent.

6. Draft #6 creates the Public Employee Benefits Oversight Committee.

PUBLIC EMPLOYEE
BENEFITS OVERSIGHT SUBCOMMITTEE

Section 2

**2005
COMMITTEE MEMBER LIST
WORK PLAN
SCHEDULE
BUDGET**

**2005 Approved
Work Plan, Meeting Schedule and Budget
of the
Public Employee Benefits Oversight Subcommittee**

The public employee benefits oversight subcommittee, a subcommittee of the legislative council, was created to ensure that benefit programs of the general services department's risk management division, the public school insurance authority, the retiree health care authority and the Albuquerque public schools are providing the best possible programs for their employees and are operating in a fiscally sound manner.

Members

Sen. Dianna J. Duran
Sen. John T. L. Grubestic
Rep. Ted Hobbs

Rep. Ben Lujan
Sen. Lidio G. Rainaldi
Rep. Sheryl Williams Stapleton

Advisory Members

Sen. Sue Wilson Beffort
Rep. Ernest H. Chavez
Rep. James Roger Madalena

Sen. Leonard Lee Rawson
Sen. James G. Taylor
Rep. Teresa A. Zanetti

Staff for the subcommittee will be provided by Pamela Ray, Lisa Barsumian, Maha Khoury and Phil Lynch.

Work Plan

The subcommittee shall receive public testimony and review:

- (1) the statutes, constitutional provisions, regulations and court decisions governing the benefit plans provided by the retiree health care authority, the public school insurance authority, the Albuquerque public schools benefits program and the state group benefits program;
- (2) the present and future costs of maintaining the programs;
- (3) present enrollment, trends in enrollment over the last five years and projected future enrollment;
- (4) comparative premium burden with similar benefits programs;
- (5) benefits coverage changes;
- (6) cost shifting used to maintain lower premiums, such as higher deductibles and increased co-pays;
- (7) balancing enrollment of younger and older members to ensure continued fund health;
- (8) actuarial soundness and performance of program funds and term of actuarial analyses;
- (9) investment of reserves and premium funds and five-year comparison of return on the investment of the reserves and premium funds;
- (10) extent and effect of participation required by statute or lack of statutory

requirement to participate in benefits programs;

(11) contractual relationships with third-party providers, administrators and agents;

(12) participation by counties and municipalities, arguments for and against;

(13) current board members, consultants and conflicts of interest;

(14) report on the small employers participation program administered by the general services department;

(15) extent and purpose of expenditures by health plans that are not related directly to benefit coverage;

(16) size of reserve funds and source of indemnification if reserves prove inadequate;

(17) legislative proposals affecting benefits programs;

(18) where the authority resides to change benefit plans and the legislature's roll in oversight of changes;

(19) the scope of the authority to refuse membership to a public group that qualifies, the criteria for refusal and recourse of a public entity that is refused; and

(20) any other pertinent area of inquiry that arises during the course of reviewing information presented to the subcommittee.

The subcommittee shall report its progress to the legislative council no later than December 2005.

Approved Meeting Schedule and Budget

In addition to its organizational meeting on July 12, the subcommittee proposes to hold four one-day meetings during the interim. Meetings will be in Santa Fe in room 317 of the capitol.

<u>Date</u>	<u>Voting Members</u>	<u>Advisory Members</u>
July 12	\$ 1,887.83	\$ 2,334.51
August 8	1,887.83	2,334.51
September 1	1,567.83	1,974.51
October 19	1,567.83	1,974.51
November 14	<u>1,567.83</u>	<u>1,974.51</u>
TOTAL	\$ 8,479.15	\$10,592.55

PUBLIC EMPLOYEE
BENEFITS OVERSIGHT SUBCOMMITTEE

Section 3

2005 AGENDAS

Revised: July 8, 2005

TENTATIVE AGENDA
for the
FIRST 2005 MEETING
of the
PUBLIC EMPLOYEES BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL

July 12, 2005
State Capitol
Room 317
Santa Fe, New Mexico

Tuesday, July 12

- 10:00 a.m. **Call To Order**
- 10:05 a.m. **Work Plan and Meeting Schedule Development**
—Pamela Ray, Staff Attorney, Legislative Council Service
- 10:30 a.m. **General Services Department Risk Management Employees Group
Benefits Programs**
—Ed Lopez, Secretary, General Services Department (GSD)
—Manuel Tijerina, Acting Director, Risk Management
Division, GSD
—Don Gonzales, Deputy Director, Risk Management Division, GSD
- 11:45 a.m. **Retiree Health Care Authority Benefits Program**
—Milton Sanchez, Director, Retiree Health Care Authority
- 1:00 p.m. **Adjournment**

Revised: August 3, 2005

TENTATIVE AGENDA
for the
SECOND MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL

August 8, 2005
Room 317, State Capitol

Monday, August 8

- | | |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10:00 a.m. | Call to Order |
| 10:05 a.m. | Public School Insurance Authority Employee Benefits Programs
—Sammy J. Quintana, Director, Public School Insurance
Authority (PSIA)
—Christy Edwards, Deputy Director, PSIA |
| 11:30 a.m. | Albuquerque Public School Benefits Program
—Tom Savage, Deputy Superintendent for District Resources,
Albuquerque Public Schools
—Vera Dallas, Director, Employees Benefits Division, Albuquerque
Public Schools
—Andrea Tybus, Director, Human Resources, Albuquerque Public
Schools |
| 12:30 p.m. | Public Comment |
| 1:00 p.m. | Adjournment |

Revised: August 31, 2005

TENTATIVE AGENDA

for the

THIRD MEETING

of the

PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

September 1, 2005

State Capitol, Room 317

Santa Fe, New Mexico

Thursday, September 1

10:00 a.m. **Call to Order**

10:05 a.m. **Comparison of IBAC Agency Benefits Programs**

—Manuel Tijerina, Acting Director, Risk Management Division,
General Services Department

—Sammy J. Quintana, Director, Public School Insurance Authority (PSIA)

—Christy Edwards, Deputy Director, PSIA

—Tom Savage, Deputy Superintendent, Albuquerque Public Schools

—Vera Dallas, Director, Employee Benefits Division,
Albuquerque Public Schools

—Christine Tessman, Interim Director, New Mexico Retiree Health Care Authority

12:30 p.m. **Public Comment**

1:00 p.m. **Adjournment**

Revised: October 18, 2005

TENTATIVE AGENDA
for the
FOURTH 2005 MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL

October 19, 2005
Room 317, State Capitol

Wednesday, October 19

10:00 a.m. **Call to Order**
 Approval of Minutes
 —August 8, 2005
 —September 1, 2005

10:05 a.m. **Discussion with IBAC Agencies**

- Who is on the board and what are their qualifications?
- What is the decision-making process used to create your benefits plan?
- What is the board involvement in decision-making regarding development of plans?
- Does the agency solicit feedback from participants to allow assessment of the adequacy of each health benefits plan?
- What is the source of the funding for in-house administration of your benefits plan?
- Are there any provisions of the statutes governing your agency that impede the ability of your agency to deliver the optimal health care coverage to your members?

Presenters and Board Members

- Risk Management Division, General Services Department
—Manuel Tijerina, Acting Director
- New Mexico Public School Insurance Authority (NMPSIA)
—Sammy J. Quintana, Executive Director, NMPSIA
—Christy Edwards, Deputy Director, NMPSIA
—Lowell Irby, Board Chair, NMPSIA
—Jose Cano, Vice Chair, NMPSIA
- New Mexico Retiree Health Care Authority (NMRHCA)
—Christine Tessman, Acting Director, NMRHCA

- LeRoy H. Garcia, Board Chair, NMRHCA
- Danielle Wilson, Board Vice Chair, NMRHCA
- Albuquerque Public Schools (APS)
 - Tom Savage, Deputy Superintendent for District Resources, APS
 - Paula Maes, President, APS Board of Education
 - Leonard J. DeLayo, APS Board Member, Finance Committee Chair
 - Andrea Trybus, Executive Director, Human Resources, APS
 - Vera Dallas, Benefits Manager, Employees Benefits Division, APS

12:30 p.m.

Public Comment

1:00 p.m.

Adjournment

**TENTATIVE AGENDA
for the
FIFTH 2005 MEETING
of the
EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
NEW MEXICO LEGISLATIVE COUNCIL**

November 14, 2005
State Capitol
Room 317
Santa Fe

Monday, November 14

10:00 a.m. **Call to Order**
Approval of October 19, 2005 Minutes

10:05 a.m. **Other Benefit Packages**

- Susan Carkeek, Director, Human Resources, University of New Mexico
- Diana Quintana, Director, Human Resources, New Mexico State University (NMSU)
- Janet May, Assistant Director, Employee Benefits, NMSU

11:30 a.m. **Municipal and County Benefit Options**
—Ed Zendel, Director of Risk Services, New Mexico Municipal League

12:30 p.m. **Lunch**

1:45 p.m. **Proposed Changes in Risk Management Benefit Plans**
 —Manuel Tijerina, Acting Director, Risk Management Division
 (RMD), General Services Department (GSD)
 —Don Gonzales, Deputy Director, Risk Management Finance,
 RMD, GSD

2:45 p.m. **Legislation Review**
—Pam Ray, Staff Attorney, Legislative Council Service

Risk Management—Group Benefits Act
 Section 10-7B-2 NMSA 1978—Include tribes or tribal consortium providing services to tribes
 Section 10-7B-3—Meeting requirement for "group benefits committee"
 Section 10-7B-6 through 10-7B-8—State and local government participation in benefits plans, fund and investment of fund (background)

Retiree Health Care Authority—Retiree Health Care Act

Section 10-7C-4 NMSA 1978—Change dependents' upper age to 25, allow the same dependents access to plan as is allowed under employee's plan while employed and include tribes as eligible employer

Sections 10-7C-9 and 10-7C-12—Cover participation and preexisting conditions

Section 10-7C-15—Contributions

Section 10-7C-17—Senior Prescription Drug Program—Remove age requirement

Public School Insurance Authority (PSIA)

Section 22-29-3 NMSA 1978—Allow APS to opt into PSIA

Section 22-29-5 Board Members—Experience in developing or evaluating benefits plans

Section 22-29-6—Fund provisions

Section 22-29-10—Contribution requirements

3:30 p.m.

Public Comment

4:00 p.m.

Adjourn

PUBLIC EMPLOYEE
BENEFITS OVERSIGHT SUBCOMMITTEE

Section 4

2005 MINUTES

**MINUTES
of the
FIRST MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL**

**July 12, 2005
State Capitol, Room 317
Santa Fe, New Mexico**

The first meeting in 2005 of the Public Employee Benefits Oversight Subcommittee of the Legislative Council was called to order by Representative Ben Lujan, chair, on Tuesday, July 12, 2005, at 10:13 a.m. in Santa Fe in Room 317 of the State Capitol.

PRESENT

Rep. Ben Lujan, Chair
Sen. Dianna J. Duran
Sen. John T.L. Grubestic
Rep. Ted Hobbs

ABSENT

Sen. Lidio G. Rainaldi
Rep. Sheryl Williams Stapleton

Advisory Members

Rep. Ernest H. Chavez
Rep. James Roger Madalena
Rep. Teresa A. Zanetti

Sen. Sue Wilson Beffort
Sen. Leonard Lee Rawson
Sen. James G. Taylor

Staff

Pamela Ray
Tim Crawford

Tuesday, July 12

Work Plan, Schedule and Budget Review

The Public Employee Benefits Oversight Subcommittee reviewed its work plan presented by Pam Ray, staff attorney, Legislative Council Service, and adopted the following provisions unanimously:

The subcommittee shall receive public testimony and review:

- (1) the statutes, constitutional provisions, regulations and court decisions governing the benefit plans provided by the New Mexico Retiree Health Care Authority (NMRHCA), the Public School Insurance Authority, the Albuquerque Public Schools benefits program and the state group benefits program;
- (2) the present and future costs of maintaining the programs;
- (3) present enrollment, trends in enrollment over the last five years and projected future enrollment;
- (4) comparative premium burden with similar benefits programs;
- (5) benefits coverage changes;
- (6) cost shifting used to maintain lower premiums, such as higher deductibles and

increased co-pays;

(7) balancing enrollment of younger and older members to ensure continued fund health;

(8) actuarial soundness and performance of program funds and terms of actuarial analyses;

(9) investment of reserves and premium funds and a five-year comparison of return on the investment of the reserves and premium funds;

(10) extent and effect of participation required by statute or lack of statutory requirement to participate in benefits programs;

(11) contractual relationships with third-party providers, administrators and agents;

(12) participation by counties and municipalities, arguments for and against;

(13) current board members, consultants and conflicts of interest;

(14) report on the small employers' participation program administered by the General Services Department (GSD);

(15) extent and purpose of expenditures by health plans that are not related directly to benefit coverage;

(16) size of reserve funds and source of indemnification if reserves prove inadequate;

(17) legislative proposals affecting benefits programs; and

(18) any other pertinent area of inquiry that arises during the course of reviewing information presented to the subcommittee.

The subcommittee will meet for four additional meetings in 2005. All meetings will begin at 10:00 a.m. and will be held in Room 317 of the State Capitol in Santa Fe. The meeting dates are:

Monday, August 8, 2005

Thursday, September 1, 2005

Wednesday, October 19, 2005

Monday, November 14, 2005.

General Services Department — Group Benefits Programs

Ed Lopez, secretary of general services, presented information about the group benefits programs administered by the Risk Management Division (RMD) of the GSD. Manuel Tijerina, acting director, RMD, GSD, and Don Gonzales, deputy director, RMD, were also present to answer questions as needed. The package of materials provided to the subcommittee is available in the meeting file.

Secretary Lopez identified the participants in the group benefits programs as employees of local public bodies, 72 of which are members of RMD programs. These include state employees, counties, incorporated municipalities and others such as housing authorities, soil and water conservation districts and regional educational cooperatives. Small businesses will soon be included in the programs also.

Benefits plans offered include:

- medical insurance, administered by Cigna, Blue Cross/Blue Shield and Presbyterian;
- prescription drug coverage by Express Scripts;
- dental coverage provided by Delta Dental;

- legal coverage;
- group life insurance (basic, supplemental and dependent, both term and whole life);
- vision insurance;
- flexible spending (a new transportation benefit);
- employee assistance;
- disability; and
- long-term care insurance.

Secretary Lopez further noted that more than 60,000 people are served by the group benefits programs of the RMD and the programs are self-insured. The contracts include "most favored nation" provisions that require that services be provided by the administrators at the lowest rate provided by the contractor to any other organization purchasing services from it. GSD sets its own rates, hires outside auditors to perform program audits and provides enrollment administration for all of the local public bodies. This number includes both employees and their eligible dependents. He discussed the rising costs of health care and noted that the national rate of increase in health benefit programs is 10 percent to 14 percent per year. The increase in the cost of health benefit programs in fiscal year 2005 and projections for fiscal years 2006 and 2007 are as follows:

<u>FISCAL YEAR</u>	<u>PERCENT INCREASE</u>
2005	11%
2006 (budgeted)	5%
2007 (projected)	7%.

GSD is required by the Health Care Purchasing Act to cooperate through the Interagency Benefits Advisory Committee (IBAC) with the NMRHCA, the Public School Insurance Authority and the Albuquerque Public Schools benefits programs to purchase administration of their benefits programs. GSD has an independent RFP for benefits not common to IBAC programs. The contract with the administrators is for a four-year period. Copies can be supplied to the subcommittee upon request.

The RMD is required to keep all funds actuarially sound, even though they are backed by the state general fund. Money in the fund comes from contributions from employees and employers and from earnings on the fund. This is an enterprise-funded activity of GSD; no general fund money is appropriated to operate the benefits programs. The benefits programs have not run into financial difficulties because they can raise contribution levels as required to meet the program costs and GSD can also reach out and increase the number of members and reduce overall costs by taking in new member local public bodies. Local public bodies sign on with the state to:

- reduce premium rates;
- shift administration to GSD and its third-party administrators; and
- provide more and better benefit programs than they can purchase individually.

GSD has also been able to make the plan more attractive by reducing deductibles for primary care while increasing deductibles for emergency room care. This shifts people into seeing their primary care physicians for preventative care while reducing emergency care due to failure to seek preventative care. The ability of GSD to hold down premium increases is also very

attractive to local public bodies that are offering benefits through third-party insurers.

Some counties and municipalities have chosen not to participate. Larger municipalities and counties are many times self-insured and do not participate in the state programs. Savings are more likely realized when a municipality or county must contract with a third-party insurer. Seventeen new public bodies joined the GSD program in 2004. The definition of "local public body" excludes nonprofit organizations and tribal governments. GSD has been actively promoting membership in the state benefits programs to spread the risk and reduce costs. The New Mexico Municipal League offers risk insurance such as liability and property damage for municipalities, but it does not offer medical and ancillary health programs. Legislators may participate in the GSD benefits programs but are required to pay 100 percent of the premium cost. Fewer than 20 legislators have chosen to participate in the plan. The Public Regulation Commission does not regulate the benefits programs of GSD because GSD is not an insurance carrier. The benefits programs are self-insured.

The small employers' benefits program is in the process of determining how it will capitalize the plan. In addition, eligible employers have to be identified. They must not have had insurance coverage for one year or more prior to applying to the state plan.

The speaker asked for more information in the future on the rate stabilization reserve.

Retiree Health Care Authority Benefits Programs

Milton Sanchez, director, and Dr. Christine L. Tessmann, deputy director, both of the NMRHCA, presented information about the NMRHCA benefits programs. Mr. Sanchez described the benefit program of the NMRHCA. Materials provided to the subcommittee members are in the meeting file. The NMRHCA Board has 11 members. The New Mexico Association of Counties was recently added as a member to the board. There are approximately 36,000 members served by the program. About 12 of the members are retired legislators. Enrollment is not mandatory. Of the 36,000 members served, 2,500 are enrolled in ancillary plans only, not in the medical plan. Since 1996, 18 or 19 employers have been added to the membership. The NMRHCA also offers a senior prescription drug program and is currently determining how it will interface with the Medicare Part D proposal from the federal government that will go into effect soon. The coverage will follow members and serve them in their communities or wherever they travel.

The total projected income for NMRHCA for fiscal year 2006 is \$142.4 million. Twenty-eight percent of the total projected revenue is expected to come from participating employers, or \$40.12 million. Full-time employees will contribute approximately 14 percent of total revenue, or \$20.06 million. A distribution from the Tax Administration Suspense Fund provides an estimated six percent of NMRHCA total revenues, or \$8.5 million, which was initiated in the 1990s when the state retiree tax exemption was terminated due to a court decision that found the exemption was unconstitutional unless it was given to all retirees. Retirees who are enrolled participants pay 48 percent of the total revenue of NMRHCA, which is approximately \$68.6 million. The total percentage of medical, pharmacy and basic life insurance paid by retirees is 41 percent and retirees pay 100 percent of the premiums of voluntary plans (dental, vision, supplemental life

insurance and long-term care).

As of July 1, 2005, contribution rates have increased. Employers will be contributing 1.3 percent of their payroll. Employees pay 0.65 percent of their salaries. The distribution from the Tax Administration Suspense Fund is increased by 12 percent annually.

The average annual contribution of an employee is \$208. The average employer and employee contribution is \$624 annually, per employee.

Deficits that occur in the program can be covered by the money in the program's trust fund, administered and invested by the State Investment Council. The current balance in the fund is \$138,635,829. This is within \$1 million of the projected balance for this year. It now looks like the fund will outperform expectations for the year.

When the NMRHCA was created in 1990, the program was expected to be insolvent by 1999. Changes were implemented that were predicted to keep the program solvent through 2006. In 1996, the program was again altered to provide solvency for a 25-year period. The performance measures for NMRHCA only require that actuarial soundness be projected for 15 years. Some projected assumptions regarding the Medicare population were not realized and now the projected solvency is for 24 years if modifications are made. However, an actuarial study in 1999 found the program to have an expectation of solvency only through 2012. The current changes were suggested and, due to their implementation and a better than expected return on investment of the funds, the current solvency projection exceeds 25 years.

Implementation of Medicare Part D (prescription drug benefits) will help to increase the soundness of the programs. This may occur in two ways. Some members may choose to use the federal prescription programs, which reduce the drug benefits costs to NMRHCA, and benefits for those who choose the NMRHCA drug plan may be redirected to the NMRHCA.

The self-insured programs are administered by Blue Cross/Blue Shield-New Mexico (BC/BSNM) or Presbyterian for the non-Medicare members. The programs are preferred provider organizations (PPO). Deductibles and coinsurance payments are required for either administrator. The deductibles are for visits to in-network physicians who do not provide basic care and range from \$100 to \$800 depending on the level of contribution provided by the member. After the deductible is exhausted, then a percentage of 10 percent to 25 percent is paid for each visit as coinsurance, again with higher coinsurance amounts to obtain a lower member contribution. For the most frequently accessed services (doctors, urgent care and emergency room visits) a flat co-pay fee is retained. Medicare members also receive services administered by Lovelace Senior. Sixty percent of the NMRHCA members are Medicare eligible. The change to PPO plans caused some drop in satisfaction with the programs.

The average increase in plan costs to NMRHCA has been about 9.5 percent each year for the last three years. Increases in health care program costs nationally run 15 percent. For enhanced medical plans, NMRHCA did not increase the cost in fiscal year 2005 and some

members will see their medical plan contributions decrease by an average of \$122. A four percent increase in membership is expected in fiscal year 2006.

NMRHCA is a member of the IBAC, as is the risk management benefits programs. The IBAC serves to allow cooperative purchasing of administrative services. NMRHCA chose to only engage two administrators, rather than three. BC/BSNM and Cigna use the same provider network, so NMRHCA felt it was not necessary to engage both BC/BSNM and Cigna. Claims now constitute the greatest expense of the program, averaging \$4,200 per member.

Employers that did not join NMRHCA in 1990 (the city of Santa Fe is a new member) are now required to buy into the program. Santa Fe is contributing \$2.5 million to join now. The required payment to buy in to the system may be paid over a 13-year period. Retirees of a member employer may enroll in the program as long as they are receiving pension benefits. If the retiree enrolls at retirement, no health statement is required. In addition, if the retiree returns to work and is covered by a health plan, then retires from that employment or has coverage involuntarily terminated, the retiree can also enroll with no health statement. Also, a retiree who is insured on a spouse's plan and then is involuntarily terminated from that plan may enroll without a health statement. Finally, if the retiree involuntarily loses individual coverage that the retiree purchased after retirement, the retiree will not be required to submit a health statement. However, if the retiree chooses to wait before enrolling and has no coverage or cancels coverage, a health statement will be required. Approximately 78 percent of retired PERA members enroll in the NMRHCA program. The remainder may choose not to participate because they are insured through a working spouse's program. Some people do not wish to expend the funds and rely on Medicare. Occasionally, a retiree returns to work and is covered by another medical program.

Adjournment

The subcommittee adjourned at 12:35 p.m.

**MINUTES
of the
SECOND MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL**

August 8, 2005

**State Capitol, Room 317
Santa Fe, New Mexico**

The second meeting in 2005 of the Public Employee Benefits Oversight Subcommittee of the Legislative Council was called to order by Representative Ben Lujan, chair, on Monday, August 8, 2005, at 10:18 a.m. in Santa Fe in Room 317 of the State Capitol.

PRESENT

Rep. Ben Lujan, Chair
Sen. Lidio G. Rainaldi, Vice Chair
Sen. Dianna J. Duran
Rep. Ted Hobbs
Rep. Sheryl Williams Stapleton

ABSENT

Sen. John T.L. Grubescic

Advisory Members

Sen. Sue Wilson Beffort
Rep. Ernest H. Chavez
Rep. James Roger Madalena

Sen. Leonard Lee Rawson
Sen. James G. Taylor
Rep. Teresa A. Zanetti

Staff

Pamela Ray
Lisa Barsumian
Tim Crawford

Guests

The guest list is in the meeting file.

Monday, August 8

Handouts can be found in the original meeting file or in the library file at the Legislative Council Service.

PUBLIC SCHOOL INSURANCE AUTHORITY BENEFIT PLANS

Sammy Quintana, executive director, Christy Edwards, deputy director, and Robert Romero, comptroller, appeared on behalf of the Public School Insurance Authority (PSIA). After an introduction by Mr. Quintana and a general description of the types of benefit programs offered by PSIA, Ms. Edwards presented the details of the various plans.

There are 160 member agencies participating in PSIA. Members include:

- 88 of the 89 school districts;
- 50 charter schools;
- 18 other educational entities (e.g., TVI, Santa Fe Community College); and
- four self-pay groups such as board members or people receiving benefits pursuant to COBRA.

A list of affiliations of PSIA board members is in the handout on the third page following the cover sheet. The fourth page includes the names of the board members.

Funding for PSIA comes from appropriations by the legislature to the Public Education Department and Higher Education Department for insurance coverage. Employees' contributions are deducted from each paycheck and are pooled to pay for medical care provided to employees. The contribution is split between the employer and the employee, with the percentage paid by an employee increasing as the salary of the employee increases. At a salary level of \$25,000, the percentage paid by the employee stabilizes at 40 percent of the total contribution. An employer can pay up to 80 percent of the contribution for employees if the employer elects to do so.

In 2006, it is anticipated that PSIA will receive \$236 million in contributions and fees. Medical claims constitute 68 percent of the expenditures of PSIA. "Administrative service only" (ASO) fees are six percent of the expenditures of PSIA. A breakdown of other expenditures from PSIA income is on page 7 of the handout.

PSIA has an average annual increase in costs of 8.5 percent, compared to a national average increase of 12 to 14 percent. It was projected that prescription costs would rise by 16 percent in claims year (CY) 2005, but PSIA saw an increase closer to 6.5 percent.

The PSIA benefits fund balance in CY 2005 was about \$23 million and is estimated to be about \$17 million in CY 2006. A reserve fund of five to eight percent of the benefits fund is retained for extraordinary claim expenses. The fund reserve is anticipated to be \$19 million for CY 2006.

As a member of the Interagency Benefits Advisory Committee (IBAC), PSIA saved \$1 million in CY 2005 in fixed costs. Because IBAC has a total of 160,000 consumers participating in its members' programs, the four members are able to reduce the cost of their administrative contracts

considerably for each member.

PSIA has contracted with Blue Cross/Blue Shield of New Mexico (BC/BS) and Presbyterian (Pres) to administer its claims. There is a "high" and a "low" option in each plan. Thirty-one percent of PSIA employees chose Pres for their insurance administrator and 69 percent chose BC/BS. Both plans are emphasizing preventative care for employees and rates are set to encourage visits to a family practice doctor or other primary care physician over an emergency room visit or a visit to a specialist.

Prescription coverage has three tiers of copays. If a generic drug is prescribed or can be substituted, the copay is the lowest amount. If the drug prescribed has no generic or the physician explicitly requires a name-brand drug and the drug is listed on the formulary developed by Express Scripts, the copay is the mid-amount. The highest copay is for name-brand prescriptions that are not on the formulary and have no generic corollary. The copays charged for prescriptions that can be bought for three months at a time through the mail prescription service have a separate schedule of copay, that are also based on a three-tiered copay system.

Preventive care is encouraged by PSIA; however, in CY 2004, 77 percent of the women members used preventive health programs, while only 19 percent of men participate in preventive health programs. The "healthy vistas" program helps keep costs contained by providing comprehensive health management. A care guide, health risk assessments, disease and lifestyle management, a 24-hour nurse help line and wellness incentives are available to help manage a member's health care.

PSIA also has found that the most frequently used prescriptions are first, depression and anti-anxiety medications; second, Lipitor to control cholesterol; third, anti-inflammatory medications; and fourth, prescription contraceptives.

A three percent contribution rate increase will begin for members in October 2005. This will raise the cost per family to \$945 per month for BC/BS. Most of this increase is being covered by using the reserves to reduce the impact on members.

Discussion included:

- why the percentages paid by the member and the employer top out at \$25,000 rather than increasing the percentage paid for members with higher salaries;
- differences between rural and metropolitan reimbursement rates for providers;
- use of in-state and out-of-state contractors;
- why Gallup-McKinley schools are considering leaving PSIA;
- use of performance measures to switch members from reliance on anti-anxiety medications to increased exercise, prevention and education;
- who is able to claim the tax exemption for medical services;
- creation of the formulary for Express Scripts;
- how the delay in identifying new or any providers in smaller cities until the following year leaves many areas of the state without in-network providers;
- the relative benefits and risks of using reserves to cushion increases in member

- contributions rather than building reserves at the cost of increased contribution burdens on members; and
- comparison with Risk Management Division programs to increase copays and coinsurance to keep contribution levels down rather than use reserves.

ALBUQUERQUE PUBLIC SCHOOLS BENEFITS PLAN

Tom Savage, deputy superintendent, Albuquerque Public Schools (APS), Andrea Tybus, director of human resources, APS, and Vera Dallas, director, Employees Benefits Division, APS, presented the benefits offered by APS.

After a brief introduction by Mr. Savage, Ms. Dallas provided the details of the APS plans. Two PPO plans are offered to employees of APS. The plans are administered by Cigna and Presbyterian. A primary care physician is not required, but out-of-network physicians require satisfaction of an initial deductible and then a coinsurance payment. Prescriptions are covered by Express Scripts. The dental plan is administered by United Concordia, which has 200 in-network dentists outside of Albuquerque and 400 in-network dentists within Albuquerque. Vision insurance is also offered. There are several other optional benefit plans that provide life insurance, long-term disability insurance and other various programs. Like other IBAC agencies, APS is self-insured. Because it is self-insured, APS (as well as other IBAC agencies) is able to raise its premium rate annually and does not contract to receive services for a set contract rate for a set contract period. APS anticipates its premiums will increase by six percent to nine percent in CY 2007. Right now, APS has insufficient reserves (\$4 million) to be considered actuarially sound. The reserves for APS need to be \$9 million. Current copays for the APS programs are less than those for PSIA.

ADJOURNMENT

The committee adjourned at 2:10 p.m.

**MINUTES
of the
THIRD MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL**

**September 1, 2005
State Capitol, Room 317
Santa Fe, New Mexico**

The third meeting in 2005 of the Public Employee Benefits Oversight Subcommittee of the Legislative Council was called to order by Representative Sheryl Williams Stapleton at the request of Ben Lujan, chair, on Thursday, September 1, 2005, at 10:26 a.m. in Santa Fe in Room 317 of the State Capitol.

PRESENT

Rep. Ben Lujan, Chair
Sen. Dianna J. Duran
Rep. Ted Hobbs
Rep. Sheryl Williams Stapleton

ABSENT

Sen. Lidio G. Rainaldi, Vice Chair
Sen. John T.L. Grubescic

Advisory Members

Sen. Sue Wilson Beffort
Rep. Ernest H. Chavez
Rep. James Roger Madalena
Rep. Teresa A. Zanetti

Sen. Leonard Lee Rawson
Sen. James G. Taylor

Staff

Pamela Ray
Lisa Barsumian
Tim Crawford

Guests

The guest list is in the meeting file.

Thursday, September 1

Handouts can be found in the original meeting file or in the library file at the Legislative Council Service (LCS).

COMPARISON OF MEDICAL BENEFITS PLANS BETWEEN IBAC AGENCIES

Lisa Barsumian, researcher, LCS, summarized the tables she prepared comparing various aspects of the four interagency benefits advisory agencies (IBAC): the Risk Management Division (RMD) of the General Services Department; New Mexico Retiree Health Care Authority (NMRHCA); Public School Insurance Authority (NMPSIA); and Albuquerque Public Schools Benefits Program (APS).

There were three tables. **Table #1 (ivory)** compared:

- the number of enrollees in each plan;
- the administrative services only (ASO) fees;
- the share of premiums that are paid in each plan by the employee and the employer;
- the current fund balances;
- the claims year (CY) 2005 amount of claims paid for use of the prescription plan and medical plan; and
- the projected claims for use of the prescription plans and medical plans for CY 2006.

Table #2 (lavender) compared plans offered by each IBAC agency:

- the costs of copayments or coinsurance, office visits, lab tests, routine physicals, immunization, specialists, emergency room visits, inpatient hospital care, maternity inpatient care and outpatient surgery;
- gross monthly premiums;
- deductibles; and
- out-of-pocket maximums for services.

Table #3 (green) compared:

- prescription drug coverage;
- vision coverage; and
- dental plans.

DISCUSSION

Vera Dallas, APS, and Christy Edwards, NMPSIA, provided their perspectives on the benefits derived by their members from continuing to have their programs remain separate. Ms. Dallas noted that the location of APS in the Albuquerque metropolitan area benefits its members and allows the program to keep costs down for its smaller population (approximately 16,000) due to the competition between health care service providers in the city. Ms. Edwards noted that NMPSIA has a broader network of care providers located throughout the state. NMPSIA covers rural areas as well as metropolitan areas, and has a broad network of providers in rural areas. Its savings are derived from the number of members in the program (approximately 60,000). NMPSIA and APS boards have adopted different policies regarding copays and premiums. APS has higher monthly premiums and lower copays, which tend to encourage people to use preventive care, while NMPSIA has lower monthly premiums and higher copays, allowing NMPSIA members to take home more of their earnings in their paychecks and hopefully use medical practitioners more judiciously. See the chart below to compare premiums within and across plans.

PREMIUMS

AGENCY		BC/BS			PRES			CIGNA		
		HI	MED	LO	HI	MED	LO	HI	MED	LO
RMD	IND		\$364			\$286			\$302	
	FAM		\$975			\$786			\$831	
NMPSIA	IND	\$371		\$312	\$289		\$243			
	FAM	\$945		\$794	\$809		\$809			
APS	IND					\$348			\$329	
	FAM					\$875			\$940	
NMRHCA	IND	\$133	\$98	\$90	\$133	\$98	\$90			
	SPSE	\$253	\$227	\$212	\$253	\$227	\$212			

Observations:

APS covers the smallest group of people at 16,668. RMD (60,000) and NMPSIA (59,473) cover roughly the same number of people. NMRHCA provides coverage to just over half as many people (36,292) as does RMD. ASO fees vary between an agency's offered medical plans, depending on the plan a member has joined, and also vary between agencies (in some cases) within the same administrator. For instance, for RMD, three health care plans are offered: Blue Cross/Blue Shield (BC/BS), Cigna or Presbyterian (Pres) HMO. The following shows the ASO fees for those plans compared with the ASO fees for other IBAC agency plans:

<u>Plan</u>	<u>RMD (ASO fee)</u>	<u>NMPSIA</u>	<u>APS</u>	<u>NMRHCA</u>
• BC/BS PPO	\$18.39	\$14.35		\$14.35
• Cigna	\$15.55		\$14.40	
• Pres HMO	\$15.63			
• Pres Open Access			\$14.45	
• Pres PPO		\$14.45		\$14.45

The surplus fund balance in each of the agencies is as follows:

Agency	Fund Balance
RMD	\$ 16,300,000
NMPSIA	\$ 22,730,756
APS	\$ 4,143,115
NMRHCA	\$152,607,116

Claims for CY 2005 and projected claims for CY 2006 for each agency are as follows:

<u>Agency</u>	<u>CY 2005</u>	<u>CY 2006</u>
RMD	\$163,319,443	\$200,000,000
NMPSIA	\$164,014,000	\$182,007,500
APS	\$ 43,482,835	\$ 53,567,635
NMRHCA	\$137,298,368	\$154,474,333

RMD and NMPSIA claims are similar for CY 2005, which might be expected since the populations are of a similar size and basically have members across all adult age groups. NMPSIA, which has 1,000 fewer members, had \$1 million more in claims and has projected it will increase its claims for 2006 by \$20 million less than RMD has projected. NMPSIA has not completed its CY 2005, so this number is also a projected total for the year. APS, which has between one-fourth and one-third the number of members of RMD, has claims in an amount that reflect that ratio for CY 2005. The claims amount for APS is also a projection, since its claims year will not end until December 2005. NMRHCA has slightly more than one-half the number of retiree members of RMD (36,000 versus 60,000) but has had 84 percent of the claims of RMD, which may be a reasonable claims level considering the age of the population that NMRHCA serves. The claims year for NMRHCA is also a projection, because this claims year is an 18-month period ending on December 31, 2005 due to a shift to synchronize the claims year with Medicare D.

CLAIMS YEAR

RMD	July 1 through June 30
NMPSIA	October 1 through September 30
APS	December 1 through November 30
NMRHCA	January 1 through December 31 (beginning January 1, 2006)

A discussion ensued regarding the sources of administrative funding for the various IBAC agencies. More information is needed and will be provided for the next meeting. Questions that arose were:

- Is there duplication of administrative costs by having an administrative-services-only administrator and the in-house agency administration?
- What amount is spent on in-house administration of each program?
- What is the source of funding for in-house administration?

Christine Tessman, acting director, NMRHCA, reminded the committee that NMRHCA has five separate sources of revenue:

- contributions from currently working state employees;
- premiums paid by retirees;
- funding from the earnings on the Tax Administration Suspense fund;
- earnings from the NMRHCA reserve fund; and
- contributions from employers of currently employed state employees.

NMRHCA will increase its premiums by 2.9 percent to keep up with increased costs of delivering

services. The actuarial increase in premiums required on January 1, 2006 is 7.8 percent, but because reserve funds are being used to cover part of the increased costs, NMRHCA is able to hold the premium increase to under 3 percent. NMRHCA is relying on the implementation of the Medicare D federal drug benefit program to also provide revenue to the program. There is a 28 percent subsidy from federal funds that NMRHCA can capture when Medicare D is implemented. NMRHCA has had to draw on reserves only three times since it was created.

ADJOURNMENT

The committee adjourned at 12:26 p.m.

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**MINUTES
of the
FOURTH MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL**

**October 19, 2005
State Capitol, Room 317
Santa Fe, New Mexico**

The fourth meeting in 2005 of the Public Employee Benefits Oversight Subcommittee of the Legislative Council was called to order by Representative Ben Lujan, chair, on Wednesday, October 19, 2005, at 10:13 a.m. in Santa Fe in Room 317 of the State Capitol.

PRESENT

Rep. Ben Lujan, Chair
Sen. Lidio G. Rainaldi, Vice Chair
Sen. Dianna J. Duran
Sen. John T.L. Grubescic
Rep. Sheryl Williams Stapleton

ABSENT

Rep. Ted Hobbs

Advisory Members

Sen. Sue Wilson Beffort
Rep. Ernest H. Chavez
Rep. James Roger Madalena
Sen. Leonard Lee Rawson
Sen. James G. Taylor

Rep. Teresa A. Zanetti

Staff

Pamela Ray
Tim Crawford

Guests

The guest list is in the meeting file.

Wednesday, October 19

Handouts can be found in the original meeting file or in the library file at the Legislative Council Service.

DISCUSSION WITH IBAC AGENCIES

The following questions were to be answered by each of the four Interagency Benefits Advisory Committee (IBAC) agencies:

- Do you have a board that approves benefit plans for employees?
- Who is on the board and what expertise do they have that they can apply to evaluating health care plans and other benefits offered to employees?
- What is the decision-making process used to create your benefit plans?
- What is the board involvement in decision-making regarding development of benefit plans?
- What is the source of funding for in-house administration of your benefit plans?
- Are there any provisions of the statutes governing your agency that impede the ability of your agency to deliver the optimal health care coverage to your members?

Attending on behalf of the IBAC agencies were:

New Mexico Public School Insurance Authority (NMPSIA)

Lowell Irby, board chair
Jose Cano, board vice chair
Sammy Quintana, executive director
Christy Edwards, deputy director
Robert Romero, comptroller

Albuquerque Public Schools (APS)

Paula Maes, president, APS Board of Education
Tom Savage, deputy superintendent for district resources
Andrea Trybus, executive director, Human Resources
Vera Dallas, benefits manager, Employee Benefits Division

New Mexico Retiree Health Care Authority (NMRHCA)

LeRoy Garcia, board chair
Danielle Wilson, board vice chair
Christine Tessman, acting director

Risk Management Division (RMD), General Services Department

Manuel Tijerina, acting director, RMD
Don Gonzales, deputy director for risk management finance, RMD

Each agency director introduced the board members present. Manuel Tijerina, acting director, RMD, explained that there is no policymaking board that oversees the RMD benefits programs. Instead, he noted there is a "group benefits committee" that is created in Section 10-7B-3 NMSA 1978, and is an advisory committee that meets annually to advise RMD regarding the benefits plans components, administration and investment of premiums.

APS

Paula Maes, president, APS Board of Education; Tom Savage, deputy superintendent for district resources; and Vera Dallas, benefits manager, Employee Benefits Division, provided answers to the initial questions presented to the agencies. It was noted that the APS Finance Committee oversees the development of the benefits plans and approves all proposals before they go to the APS Board of Education for final approval. The finance committee meets every two weeks to discuss matters including the benefits plans. Leonard J. DeLayo, who has served on the APS Board of Education for 17 or more years, is the chair of the finance committee. The APS Board of Education is briefed on the benefits package at least annually. The changes in the benefits packages were recently approved by the APS Board of Education.

The APS staff attend IBAC meetings and reports back to the finance committee. APS has no statutory changes that it is requesting at this time. It is satisfied with the current law that allows APS to operate autonomously and to develop the best benefits package for its employees.

In-house administration of the benefits plan comes out of the APS general budget through the school funding formula. There are currently seven employees administering the benefits package. The budget for administration is approximately 0.8 percent of the funds generated by premiums.

A consulting firm, Gallagher Consulting, helps staff to develop the plan components for benefits plans. Development of the plans is a year-long process among the board, employee recipient representatives and union representatives, administration employees and consultants. The emphasis now will be on encouraging the employee recipients to manage their own use of the health benefits plan by encouraging wellness awareness. This year, there will be a six percent premium increase, part of which will go to establish a larger reserve fund to meet actuarial requirements.

APS is seeking increased input from its participating employees and is trying to determine how to increase the number of employees participating. It is clear that some employees would prefer higher premiums and lower copays and deductibles. Other employees would prefer a more streamlined, cheaper package.

There are quarterly meetings of an advisory committee that includes bargaining units and other stakeholders. The benefits package is explained at meetings of this group. APS is looking at other school districts around the country to determine if there are better ways to provide benefits.

The subcommittee requested that APS provide the subcommittee with the percentage of employees who opt out of the benefits program. If APS has the information, the subcommittee would like to know why people are not joining the program. The question arose regarding why coverage is optional.

In response to the question of how a person who has opted out of coverage can choose to become covered, Ms. Dallas noted that open enrollment occurs only once every four years. If a qualifying event occurs between open enrollment periods or if a new employee comes on board, then those employees can be admitted to the plan. After a qualifying event, an employee must apply for

coverage within 60 days following the event (e.g., termination of coverage on a spouse's policy). If there is a preexisting condition, the employee may not be covered for that preexisting condition for a 12-month period. APS has begun discussions with providers to allow open enrollment annually. The next open enrollment is scheduled for October 2008. Annual open enrollment would significantly increase premiums. The increase is due to the belief that people switch from no coverage to coverage because of diagnosed illness or another event requiring coverage.

The subcommittee noted that educational assistants are paid at a low rate and find it difficult to reduce their take-home pay to cover the cost of insurance for themselves and their family members. It was pointed out that the legislature determines the amount of funding available for paying educational assistants and it is very low.

Ms. Dallas noted that beginning in December 2005, a preexisting condition would not be covered for a new employee until 12 months following enrollment in the APS health care benefits plan.

The subcommittee questioned why the ASO companies used by APS do not require the same restrictions of the state risk management program. Concern was expressed that the consulting firm working with APS had not felt this was an important issue to bring up in negotiations.

NMPSIA

NMPSIA discussed its process for determining the details of its benefits package. Lowell Irby, Artesia School Board, chair of NMPSIA, Sammy Quintana, executive director, and Christy Edwards, deputy director, made the presentation. NMPSIA has an 11-member board that meets monthly except in January and July. Other meetings are scheduled as needed. Mr. Irby represents the School Board Association, one of the required positions on the board. The Benefits Advisory Committee is noted in the NMPSIA materials in the subcommittee file. The Benefits Advisory Committee recommends the plans to be implemented each year. ASO fees are negotiated through IBAC. NMPSIA staff and a consultant attend IBAC meetings. The NMPSIA board has rejected proposed packages and sent staff back to the drawing board with vendors to improve packages. As a self-insured entity, NMPSIA writes its own rules and determines its enrollment periods and the details of its benefit plans. Feedback on the success of the package comes from annual surveys of the members and personal contacts from them.

The medical plan insures approximately 34,000 employees of school districts around the state and other members such as universities. Employers pay a share for employees working 20 hours or more. An employee working 15 hours can obtain benefits if the employee pays 100 percent of the premiums. Seventy-four percent of the employees of member employers are enrolled in the medical plan. Open enrollment is annual and an employee can enroll at any time, but must wait for 18 months to enroll after being declined by another insurer. In open enrollment periods, a six-month wait is required for preexisting conditions but all other conditions are covered immediately.

The sources of in-house administration funding for NMPSIA are general fund appropriations to school districts for insurance coverage from the funding formula paid as the employer portion of

premiums and premiums charged to employees. Employees pay approximately 35 percent of funds coming into NMPSIA and the general fund through employer contributions covers the remaining 65 percent. As in all of the four IBAC programs, there is no third-party insurer that underwrites the costs of the medical claims of members.

The ASO providers have performance measures in their contracts and are audited by NMPSIA in a three-tiered auditing process. Auditors can find claims paid incorrectly, such as claims paid at higher rates than allowable, claims paid at lower rates than allowable or claims that are not paid that should have been paid.

As with the state RMD programs, NMPSIA changed its package to drop the need for referrals from a primary care physician. Employee members may go directly to specialists but must pay coinsurance that is a percentage of the cost of the fee allowed. This eliminates a double charge for the primary care physician and for the specialist. NMPSIA is offering flu shots and immunizations, including pneumonia shots, for no copay at select pharmacies.

The statutes (Section 22-29-1 NMSA 1978, et seq.) define who may be appointed to the NMPSIA board. The governor appoints three members and the rest comes from defined stakeholder groups. The board elects the chair.

The subcommittee suggested that all of the members should be required to have some experience in benefit package planning. NMPSIA requested that APS no longer be prohibited from joining NMPSIA if it decides to do so. Right now, 88 school districts and 50 charter schools are member employers. Also, other schools, such as Albuquerque TVI and WNMU, are employer members.

NMRHCA

Ms. Christine Tessman, acting director, NMRHCA, and LeRoy Garcia, chair, NMRHCA Board, presented the responses to the questions presented to the IBAC agencies by the subcommittee. A discussion ensued regarding an anticipated move to a new building in Albuquerque and the opening of a satellite office in Santa Fe. Ms. Tessman offered some amendments to current law that would improve the ability of NMRHCA to offer services to its retiree population. They include:

- allowing domestic partners and their children to be covered as they are now by the RMD benefit programs;
- eligibility to be covered up to age 25. While this is already law, the statute still has old language that cuts off coverage at 19 unless the dependent is a full-time student; and
- removing the age qualification for the senior prescription drug program. It is already available to the general public, but only if one is over age 65. A more basic question is should the prescription drug program be continued. Right now, 4,477 people are enrolled in the program.

The NMRHCA Board has not reviewed any of these proposals.

NMRHCA will bring in the dollar figures that it expends on in-house administration. For the last three years, no funds have been added to the reserve fund because premiums were able to only cover claims.

The statute identifies groups of stakeholders that must be represented on the board. There is no requirement that any of those appointed have experience in developing or assessing benefit programs. Only one board position, the governor's appointment, carries a term limit. The remainder of the board members are ex-officio. Recommendations are generally formulated by the staff and then presented to the board for approval. For ASO fees and administrators, IBAC negotiates the contracts and then presents the contracts to each of the four IBAC agency boards or approving authority.

NMRHCA is self-insured except for two senior programs for which it contracts. The Lovelace Senior Plan and the Presbyterian Senior Plan have less than 2,000 members at this time. As a result of being self-insured, NMRHCA does not negotiate its benefit plan premiums but sets them at a rate that will cover claims costs for the year. All IBAC agencies follow this procedure. There is an executive director's advisory committee, which was created by the previous executive director, that advises the executive director on plan design and changes. The board makes the final decisions. The IBAC survey is used to determine plan member satisfaction.

Two suggestions were made by subcommittee members for legislative proposals:

1. Tribes should be included in the RMD and NMRHCA. Also, tribes should be included in the Public Employees Retirement Association (PERA).
2. Board members should have no financial interest or other business relationship with a contractor with the board or with a third-party administrator.

In response to questions from members, Ms. Tessman stated that:

- there are two fully insured plans administered in the urban areas of the state; outside of the urban areas, there is no premium change so premiums remain the same as in the urban areas;
- ASO contracts are four-year contracts but other costs of the plans can change annually, such as premiums;
- moving to a new building in Albuquerque will save NMRHCA as much as \$40,000 per year;
- NMRHCA is considering opening an office in Las Cruces and has an office in Santa Fe; and
- the executive director's advisory committee members receive per diem and mileage. It was formed by the executive director several years ago and its purpose is to advise the executive director on changes to and the design of benefit plans. The board has no input on who is included as a member of the advisory board.

RMD

Mr. Tijerina and Mr. Gonzales responded to the subcommittee's questions.

RMD is suggesting no statutory changes. In-house administrative costs are funded by general fund money and are included in the budget of and appropriations to the General Services Department.

RMD has no governing policymaking board, but it does have an advisory board created by statute. The board has no decision-making authority, but it is required to advise RMD regarding its group benefits design, investments and other aspects of the group benefits program. Decisions are made by the director. The local public body representative is the only member that is not a state employee.

The policies that drive decision-making are:

- providing benefits that provide a healthier work force; and
- providing a plan that will encourage employees to participate in it.

The plan must be actuarially sound, and that determines when benefits must be dropped or can be increased. Calls to the division are monitored for trends that are then used to adjust the plans. RMD sponsors health fairs and wellness programs. Legislators can join the program if they pay 100 percent of the premium. Research and Polling, Inc., has also been engaged to determine member satisfaction with the benefits provided.

Subcommittee members discussed the following:

- Employees making less than \$30,000 per year in salary have 80 percent of their health care premium paid by the state; when employees earn between \$30,000 and \$50,000, the employer share falls to 70 percent; and legislators must pay 100 percent of the premium.
- Sierra Vista Hospital in Sierra County will become a member as of January 1, 2006.
- RMD presents its changes that will affect the budget to the Legislative Finance Committee; however, subcommittee members asked that proposed changes to benefit plans be presented to the subcommittee in the future.
- Mr. Tijerina noted that the staff is very lean to provide in-house administration at the lowest cost for all four IBAC agencies and noted the office could provide better service for state employees if it has additional staff.
- If an employee chooses not to enroll when first able, that employee can join the plan when there is a qualifying event, such as loss of other coverage. Pre-existing conditions are not covered immediately if enrollment is between open enrollment periods. The waiting period is 90 days. The state has open enrollment annually.

A motion was made by Senator Wilson Beffort, seconded by Representative Stapleton, that RMD advise APS regarding changing the open enrollment periods and other policy changes with which RMD has had experience. The subcommittee agreed unanimously that RMD should provide its expertise to help APS as needed.

ADJOURNMENT

The subcommittee adjourned at 1:20 p.m.

**MINUTES
of the
FIFTH MEETING
of the
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE
of the
LEGISLATIVE COUNCIL**

**November 14, 2005
State Capitol, Room 317
Santa Fe, New Mexico**

The fifth meeting in 2005 of the Public Employee Benefits Oversight Subcommittee of the Legislative Council was called to order by Senator Lidio G. Rainaldi, vice chair, on Monday, November 14, 2005, at 10:20 a.m. in Santa Fe in room 317 of the State Capitol.

Present

Rep. Ben Lujan, Chair
Sen. Lidio G. Rainaldi, Vice Chair
Sen. Dianna J. Duran
Sen. John T.L. Grubestic
Rep. Ted Hobbs

Absent

Rep. Sheryl Williams Stapleton

Advisory Members

Sen. Sue Wilson Beffort
Sen. Leonard Lee Rawson

Rep. Ernest H. Chavez
Rep. James Roger Madalena
Sen. James G. Taylor
Rep. Teresa A. Zanetti

Staff

Pamela Ray
Lisa Barsumian
Tim Crawford

Monday, November 14

Handouts are in the original meeting file or in the library file at the Legislative Council Service.

Minutes

Senator Rainaldi moved the approval of the minutes for the October 19, 2005 meeting of the Public Employee Benefits Oversight Subcommittee of the Legislative Council. Senator Duran seconded the motion. The subcommittee voted unanimously to adopt the minutes.

UNM and NMSU Benefits Plans

UNM

Susan Carkeek, director of human resources, University of New Mexico (UNM), presented information regarding the UNM benefits program. The UNM benefits program covers a total of 10,960 employees and their dependents. Out of 7,250 faculty and staff, 5,300 are enrolled in the UNM benefits plan. The premiums are slightly higher than the state group benefits costs. This is thought to be partly a result of the increased use by the School of Medicine staff and faculty, who are heavier-than-average users of medical insurance and also due in part to inclusion of retirees in the population covered by the UNM benefits program. UNM is fully insured with third-party insurers, but not self-insured. UNM is currently developing a reserve fund and hopes to be able to self-insure by the 2007 claims year. Providers of the medical insurance benefit plan are either Lovelace or United Health Care, which subcontracts with Presbyterian to provide local services. The plans have out-of-state coverage for people on sabbatical or traveling out of state.

The medical plans offer three plans. In the plans for active employees, an office visit to an in-network physician is \$10.00. Coinsurance for various care can be as much as 40 percent of the fee allowed.

It would cost more than \$6 million for employer contributions to be at the 80 percent level for all employees. The breakdown for coverage is:

SALARY RANGE OF EMPLOYEE	EMPLOYER CONTRIBUTION
• salary less than \$25,000	80%
• salary of \$25,000 to \$35,000	70%
• salary above \$35,000	60%

In the group of lowest-paid employees, the participation rate is between 47 percent and 57 percent.

Retirees are divided into those below age 65 and those age 65 and older. Those below age 65 are included in the same benefit plan as active employees. Once a retiree reaches age 65, the employee becomes eligible for Medicare and the second type of plan must be used. This type of plan has options that provide coverage that supplements and complements Medicare basic coverage. An additional 918 retirees and dependents are covered by the Medicare supplemental and complementary benefits. There are a total of 2,207 retirees who could be receiving benefits.

A third type of plan is offered to UNM Hospital (UNMH) employees. UNMH has already switched to a self-insured plan for its employees. That plan covers 3,174 employees, retirees and dependents. UNMH is a separate plan because it used to be the Bernalillo County Medical Center and then was transferred to UNM. Premiums are less for UNMH than for UNM employees.

Subcommittee members requested the profile of employees not enrolled in insurance, with the following questions:

- Of the employees in the lowest salary tier the 47 percent to 57 percent of employees who are not enrolled in the insurance program what number are married or have a covered partner?

- What number are unmarried?
- What number are single parents with children or other dependents?
- What is the average age of the employee that chooses not to enroll in the medical insurance program?
- How many years of service has the average employee not enrolled in medical insurance have?

A question arose regarding the way that student health centers are integrated into the insurance plans. At UNM, staff and employees use the Lobo Clinic as a primary care facility or urgent care clinic. The copay for employees with insurance is \$10.00 for a visit to the Lobo Clinic.

Subcommittee members questioned which community college and university campuses have student clinics. The response was that it is believed that all campuses have student clinics so that health care is available to the student population. UNM covers its staff and faculty at all of its branch campuses. Of the employees from branch campuses, 21 percent enroll in Lovelace and 16.5 percent enroll in United Health Care (Presbyterian).

As third-party insurers, Lovelace and United Health Care perform claims management, claims administration and other administration, and provide stop-loss coverage in case the claims exceed premiums. The programs offer annual open enrollment and no exclusion for preexisting conditions during open enrollment.

The dental plans used by UNM are Delta Dental and Fordice-HMO. Delta Dental is an indemnity plan to be used with any dentist. Fordice is an HMO that has in-network providers that must be used.

NMSU

Diana Quintana, director of human resources, New Mexico State University (NMSU), and Janet May, assistant director of employee benefits, NMSU, informed the subcommittee that NMSU has 3,066 employees enrolled out of a potential 4,100. Retirees are also eligible to receive coverage and 849 are enrolled. The cost of the plan for 2004-2005 was \$27,018,460.

The medical insurance carrier for NMSU is Blue Cross/Blue Shield NM (BC/BS). There are four plans offered: an HMO; a point of service plan (POS); a preferred provider option (PPO); and a managed care organization (MCO). About 74 percent of the employees enroll in the HMO; retirees under age 65 enroll in the PPO; and retirees over age 65 enroll in the MCO.

No referrals are needed in the NMSU plans and copays and coinsurance are:

- \$20.00 copay for an office visit;
- \$40.00 for an urgent care facility visit; and
- 35 percent for a visit with a specialist.

The student health clinic is for students only and charges no fees for a visit.

The subcommittee also asked for a demographic profile of the lowest-paid employees who have not enrolled in the benefit plan. There is no open enrollment period; an employee joins when the employee is first employed or must wait for one year if that employee fails to enroll. If an employee does not enroll immediately and has a preexisting condition, the preexisting condition, is not covered for six months after enrollment.

On July 1, 2005, the NMSU medical benefit plans became self-insured. In addition, NMSU is also considering a transition into the state group benefits program. In the state group benefits plan, more employees are covered at the 80 percent level than had been covered by NMSU at that level, so now NMSU is finding the funds to cover its employees at the levels covered by the state. Right now, NMSU has a reserve fund of \$3,899,276 which is 14 percent to 16 percent of the claims for the year. Premiums have increased by the following percentages over the last three years:

<u>Fiscal Year</u>	<u>Premium Percent Increase</u>
FY 2005	4 percent
FY 2004	4.65 percent
FY 2003	12.8 percent to 28 percent

Delta Dental is the dental insurance plan that NMSU contracts with. The 2004-2005 plan costs were \$1,966,001. This is a fully insured plan, not a self-insured plan. Contracts are renewed annually up to three years before a new contract must be negotiated.

Municipal League Benefit Coverage

Ed Zendel, director of risk services, New Mexico Municipal League (NMML), presented information on the benefit plan that the NMML offers to municipalities and other local entities that can obtain insurance through the NMML's program. The pool, the New Mexico Self-Insurer's Fund Health Benefits Pool, is a program that was started in the 1960s by NMML. It was established as the Health Benefits Pool in 1994 as a fully insured product. In 1995, the program became self-insured. Currently there are 53 member employers. Forty-two of the 103 municipalities in New Mexico are members, ranging in size from Silver City to Grady, that are generally the smaller municipalities in New Mexico. Two councils of governments are members and the remaining members are three solid waste authorities, three housing authorities, one natural gas provider, the NMML and the New Mexico Association of Counties. The number of employees covered is 1,091 and 1,297 dependents, totaling 2,388 people. The participation rate of employees is approximately 60 percent; however, smaller communities tend to have a lower enrollment. On June 30, 2005, the Health Benefits Pool had \$3.36 million in members' equity in its fund. Claims paid by June 30, 2004 were \$9.05 million and the

claims paid through June 30, 2005 are expected to be about \$8.145 million. Equity held by the pool represents 37 percent to 41 percent of claims paid.

The Health Benefits Pool offers three plans to its members. Two plans are indemnity plans that have \$100 or \$200 deductibles and the costs of service is split 80 percent/20 percent with the insurer. The third plan is a PPO that uses multiple provider networks to meet members' needs. The PPO also permits enrollees to seek treatment from out-of-network providers, although the deductible and copays are more. Accommodations are made if a member cannot find a provider within a reasonable distance. The member, in that case, would pay as if the member were receiving services from an in-network provider. Prescriptions were in three tiers: generic formulary drugs have the lowest copay; brand name prescription drugs on the formulary are midrange; and drugs not on the formulary are most expensive.

Employers determine the amount they will contribute and it varies from 60 percent to 100 percent of the premiums.

Risk Management Division—Discussion of Benefits

Manuel Tijerina, acting director, Risk Management Division (RMD), presented some basic information about the group benefits program of RMD. Don Gonzales, deputy director, RMD, was on hand to help with questions. In response to concerns that RMD did not inform the legislature about changes to the group benefits program that will require additional general fund appropriations, Mr. Tijerina noted that few improvements actually increase the amount of general fund appropriations needed. The addition of the hearing aid benefit, the most recent addition to the group benefits package, increased the cost of premiums by about 0.15 percent, which did not put an additional burden on the cost of benefits to the state. Enhancements are usually only implemented when savings are anticipated that will cover the cost of the enhancement. A concern expressed from the subcommittee is that the lowest-paid employees most likely would not benefit from additions to the package such as covering partial costs of hearing aids. The dental program was changed and costs were anticipated to be reduced, which allowed for the addition of the hearing aid benefit, according to Mr. Tijerina.

The legislature has a great deal of control over the costs of the group benefits programs, according to Mr. Tijerina. The legislature by law controls the percent contribution paid by state employers and employees. The percentage paid by an employer is generally appropriated as part of the insurance budget of an agency. The legislature also controls, to some degree, the number of employees in the state through the appropriations process, which constitutes a second component of the overall amount of employer contributions that must be paid annually. The piece the legislature cannot control is premium rates, which are set based on the projected claims costs for the upcoming year and the number of employees enrolled in the group benefits program.

Premiums are set 13 to 14 months prior to the beginning of the year in which the premiums will be charged. For example, the premiums that will be charged on July 1, 2006 were set in April or May of 2005, based on RMD's best projection of the costs of the claims for fiscal year (FY) 2007. There is still some opportunity to make changes to the premiums, but information on which to base the changes will not be available until after the first of the year. Doctors do not bill for services provided until 30

to 60 days following the appointment date. RMD has just paid the bills for July and August 2005 and is now processing September and some of October's claims. There is not enough data yet to know how the new copay and coinsurance schedule will change the use of medical services and, therefore, the costs of services after July 1, 2006.

The benefits reserve fund must be actuarially sound according to statute. RMD is required to have approximately \$30.6 million in reserves, and usually holds reserves at approximately \$31 million. In FY 2005, cost containment measures were implemented, but it is too early to determine how effective they will be. For FY 2007, RMD anticipates a 9 percent increase in claims costs. As of now, 72 local bodies are participating in the RMD program. RMD is responsible for investment of its funds. The state treasurer actually invests the money, including the premiums in the self-insurance fund that will be used for paying claims.

Legislative Proposals

Pam Ray, staff attorney, Legislative Council Service, presented seven legislative proposals that have been requested or discussed during the interim.

1. Not Adopted. Bill Draft #1. The bill adds tribes, tribal consortium or subdivisions of tribes to the definition of local public body in Section 10-7B-2 NMSA 1978 to the Group Benefits Act. The subcommittee rejected this proposal due to lack of information about the fiscal impact, the need and whether tribes would be interested in participating. Questions were raised regarding the sovereignty of the tribes, whether they would choose to become involved with this plan and how many and what kind of employees would be covered potentially. Mr. Tijerina told the subcommittee that he believes all of the issues could be worked out in an agreement with a tribe choosing to become an employer member. Further discussion of the issue will be included in the work plan for the 2006 interim if the subcommittee is recreated. A motion to endorse Bill Draft #1 was made by Senator Grubestic and seconded by Senator Rainaldi. A substitute motion was made by Senator Duran not to endorse Bill Draft #1, which was seconded by Representative Hobbs. Discussion ensued. A substitute motion for the substitute motion was made by Speaker Lujan and seconded by Senator Rainaldi to table the bill until further discussion was possible. This motion passed on a three to two vote of the regular members, with Senator Duran and Representative Hobbs voting in the negative.

2. Adopted. Bill Draft #2. The draft adds a requirement to Section 10-7B-3 NMSA 1978 that the Group Benefits Committee meet at least quarterly each year. Discussion during the November meeting found that the Group Benefits Committee, an advisory subcommittee created in the Group Benefits Act, was meeting only once per year as required to elect a chair. The committee duties are extensive and should require more time to complete. The motion to endorse the bill draft was moved by Speaker Lujan and seconded by Senator Rainaldi. The bill draft was adopted on a three to two vote of the regular members, with Representative Hobbs and Senator Duran voting in the negative.

3. Adopted. Bill Draft #4. The draft amends Section 10-7C-4 NMSA 1978, the definitions for the Retiree Health Care Act, to do three things:

- raise the maximum age for coverage to 25 of unmarried dependents that are not otherwise

covered in the act to comply with changes made to statute in 2003 (SB 457), Section 13-7-8 NMSA 1978 (the Health Care Purchasing Act), that requires coverage for all unmarried adults under the age of 25;

- allowing dependents insured by a member employer plan for active employees to also be covered on the retiree health care plan; and
- including tribes as independent employers.

The motion was to adopt the bill without the language pertaining to tribes. The motion was made by Speaker Lujan and seconded by Senator Rainaldi. The vote was three to two in favor of the motion. Senator Duran and Representative Hobbs voted in the negative.

4. Adopted. Bill Draft #6. The draft amends Section 10-7C-17 NMSA 1978 (the Senior Prescription Drug Program), to remove the age limit and make the plan available to people of all ages. In addition, the name of the program will be changed to the Discount Prescription Drug Program. Speaker Lujan made a motion to adopt the draft and Senator Grubescic seconded the motion. The vote was three to two in favor of the motion. Senator Duran and Representative Hobbs voted against the motion.

5. Adopted. Bill Draft #7. The draft amends Section 22-29-3 NMSA 1978 (the definition section of the Public School Insurance Authority Act), to mandate that by December 1, 2007, the Albuquerque Public Schools (APS) join with the Public School Insurance Authority for health care coverage only. The subcommittee amended the draft to require that an additional seat on the board be a member from APS, which will be added to the board when APS joins.

6. Adopted. Bill Draft #9. The draft amends Section 22-29-10 NMSA 1978, pertaining to employer contribution levels for premiums for the Public School Insurance Authority. The proposed contribution rate changes will be:

- employee annual salary under \$20,000: the employer contribution rate for the employee and the employee's dependents will be a minimum of 80 percent;
- employee annual salary of at least \$20,000 but less than \$25,000: the employer contribution rate for the employee and the employee's dependents will be a minimum of 75 percent;
- employee annual salary of at least \$25,000 but less than \$30,000: the employer contribution rate for the employee and the employee's dependents will be a minimum of 70 percent;
- employee annual salary of at least \$30,000 but less than \$100,000: the employer contribution rate for the employee and the employee's dependents will be a minimum of 60 percent; and
- employee annual salary of \$100,000 or greater: the employer contribution rate for the employee and the employee's dependents will be a minimum of 50 percent.

Proposed maximum contribution rates will be:

- employee annual salary under \$20,000: the employer contribution rate for the employee and the employee's dependents may not exceed 90 percent;
- employee annual salary of at least \$20,000 but less than \$25,000: the employer contribution rate for the employee and the employee's dependents may not exceed 85 percent;
- employee annual salary of at least \$25,000 but less than \$30,000: the employer contribution rate for the employee and the employee's dependents may not exceed 80 percent;
- employee annual salary of at least \$30,000 but less than \$100,000: the employer contribution rate for the employee and the employee's dependents may not exceed 70 percent; and
- employee annual salary of \$100,000 or more: the employer contribution rate for the employee and the employee's dependents may not exceed 60 percent.

It will be mandatory that all employees must enroll in the medical insurance coverage unless they can demonstrate that they are covered under a comparable medical plan. Any adult employee that is approved for Medicaid coverage can opt out of the medical insurance requirement.

Speaker Lujan motioned that the draft be adopted as amended. Senator Grubescic seconded the motion. The vote was three to two in favor of the amended draft. Senator Duran and Representative Hobbs voted against the motion.

7. Adopted. Bill Draft #10. The draft creates the public employee benefits committee, with six members. This is not a council-appointed committee. Besides reviewing benefit programs, the committee will also look at other programs such as unemployment insurance, workers' compensation and retirement programs. The committee will look at how consistent the medical benefits offered are across programs and to what extent the programs are funded by the general fund or the legislature, what efficiencies can be obtained by increasing consistency in benefit programs and what economies of scale will accrue if groups that are now separate can be combined. Reserve funds and investment of premiums will be reviewed.

Speaker Lujan moved adoption of the proposal. Senator Grubescic seconded the motion. The vote was unanimous.

Adjournment

The committee adjourned at 4:28 p.m.

PUBLIC EMPLOYEE
BENEFITS OVERSIGHT SUBCOMMITTEE

Section 5

2005
LEGISLATIVE PROPOSALS

BILL

47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006

INTRODUCED BY

DISCUSSION DRAFT

FOR THE PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

AN ACT

RELATING TO PUBLIC EMPLOYEE BENEFITS; SETTING A MINIMUM NUMBER
OF MEETINGS PER YEAR FOR THE GROUP BENEFITS COMMITTEE;
DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. Section 10-7B-3 NMSA 1978 (being Laws 1989,
Chapter 231, Section 3) is amended to read:

"10-7B-3. GROUP BENEFITS COMMITTEE--CREATED.--

A. The "group benefits committee" is created. The
committee shall be composed of nine members as follows:

(1) one employee of, appointed by the
secretary of, each of the two departments of the state,
excluding state institutions of higher education, having the
largest number of full-time employees;

(2) the superintendent of insurance or [his]

.159142.1

1 the superintendent's designee;

2 (3) the director of the state personnel office
3 or [~~his~~] the director's designee;

4 (4) the executive secretary of the public
5 employees retirement association or [~~his~~] the executive
6 secretary's designee;

7 (5) the chief financial officer of a state
8 agency or institution, appointed by the governor;

9 (6) one employee of a local public body
10 participating in the state group plan, appointed by the
11 governor; and

12 (7) two public employees of state agencies,
13 other than those from whom members are appointed pursuant to
14 Paragraphs (1) through (4) of this subsection, appointed by the
15 governor.

16 B. Members of the committee appointed by the
17 governor or by a department secretary shall serve terms of four
18 years. Vacancies in appointive memberships shall be filled by
19 the appointing authority. An appointive membership shall be
20 deemed vacant when the member ceases to be a public employee or
21 ceases to meet the qualifications for [~~his~~] the member's
22 membership set forth in Subsection A of this section. An
23 appointive membership shall also be deemed vacant when the
24 member fails to attend three consecutive meetings of the
25 committee.

.159142.1

1 C. A majority of the committee shall constitute a
2 quorum. The members of the committee shall elect annually from
3 among the membership a [~~chairman~~] chair and vice [~~chairman~~]
4 chair.

5 D. The committee shall meet at least quarterly to
6 conduct its business."

7 Section 2. EMERGENCY.--It is necessary for the public
8 peace, health and safety that this act take effect immediately.

9 - 3 -

BILL

47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006

INTRODUCED BY

DISCUSSION DRAFT

FOR THE PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

AN ACT

RELATING TO RETIRED PUBLIC EMPLOYEES; AMENDING A SECTION OF THE
RETIREE HEALTH CARE ACT; EXPANDING THE DEFINITION OF ELIGIBLE
DEPENDENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. Section 10-7C-4 NMSA 1978 (being Laws 1990,
Chapter 6, Section 4, as amended) is amended to read:

"10-7C-4. DEFINITIONS.--As used in the Retiree Health
Care Act:

A. "active employee" means an employee of a public
institution or any other public employer participating in
either the Educational Retirement Act, the Public Employees
Retirement Act, the Judicial Retirement Act, the Magistrate
Retirement Act or the Public Employees Retirement Reciprocity
Act or an employee of an independent public employer;

.159144.2

1 B. "authority" means the retiree health care
2 authority created pursuant to the Retiree Health Care Act;

3 C. "basic plan of benefits" means only those
4 coverages generally associated with a medical plan of benefits;

5 D. "board" means the board of the retiree health
6 care authority;

7 E. "current retiree" means an eligible retiree who
8 is receiving a disability or normal retirement benefit under
9 the Educational Retirement Act, the Public Employees Retirement
10 Act, the Judicial Retirement Act, the Magistrate Retirement
11 Act, the Public Employees Retirement Reciprocity Act or the
12 retirement program of an independent public employer on or
13 before July 1, 1990;

14 F. "eligible dependent" means a person obtaining
15 retiree health care coverage based upon that person's
16 relationship to an eligible retiree as follows:

17 (1) a spouse;

18 (2) an unmarried child under the age of
19 [~~nineteen~~] twenty-five years who is:

20 (a) a natural child;

21 (b) a legally adopted child;

22 (c) a stepchild living in the same
23 household who is primarily dependent on the eligible retiree
24 for maintenance and support;

25 (d) a child for whom the eligible

1 retiree is the legal guardian and who is primarily dependent on
2 the eligible retiree for maintenance and support, as long as
3 evidence of the guardianship is evidenced in a court order or
4 decree; or

5 (e) a foster child living in the same
6 household;

7 (3) a child described in Subparagraphs (a)
8 through (e) of Paragraph (2) of this subsection who is [~~between~~
9 ~~the ages of nineteen and~~] under the age of twenty-five and is a
10 full-time student at an accredited educational institution;
11 provided that "full-time student" shall be a student enrolled
12 in and taking twelve or more semester hours or its equivalent
13 contact hours in primary, secondary, undergraduate or
14 vocational school or a student enrolled in and taking nine or
15 more semester hours or its equivalent contact hours in graduate
16 school;

17 (4) a dependent child [~~over nineteen~~] twenty-
18 five and over who is wholly dependent on the eligible retiree
19 for maintenance and support and who is incapable of
20 self-sustaining employment by reason of mental retardation or
21 physical handicap; provided that proof of incapacity and
22 dependency shall be provided within thirty-one days after the
23 child reaches the limiting age and at such times thereafter as
24 may be required by the board;

25 (5) a surviving spouse defined as follows:

1 (a) "surviving spouse" means the spouse
2 to whom a retiree was married at the time of death; or

3 (b) "surviving spouse" means the spouse
4 to whom a deceased vested active employee was married at the
5 time of death; ~~[or]~~

6 (6) a surviving dependent child who is the
7 dependent child of a deceased eligible retiree whose other
8 parent is also deceased; or

9 (7) a person who would qualify as an
10 employee's dependent pursuant to the provisions of a
11 participating employer's health insurance benefit plan had the
12 employee not retired;

13 G. "eligible employer" means either:

14 (1) a "retirement system employer", which
15 means an institution of higher education, a school district or
16 other entity participating in the public school insurance
17 authority, a state agency, state court, magistrate court,
18 municipality, county or public entity, each of which is
19 affiliated under or covered by the Educational Retirement Act,
20 the Public Employees Retirement Act, the Judicial Retirement
21 Act, the Magistrate Retirement Act or the Public Employees
22 Retirement Reciprocity Act; or

23 (2) an "independent public employer", which
24 means a municipality, county or public entity that is not a
25 retirement system employer;

1 H. "eligible retiree" means:

2 (1) a "nonsalaried eligible participating
3 entity governing authority member", which means a person who is
4 not a retiree and who:

5 (a) has served without salary as a
6 member of the governing authority of an employer eligible to
7 participate in the benefits of the Retiree Health Care Act and
8 is certified to be such by the executive director of the public
9 school insurance authority;

10 (b) has maintained group health
11 insurance coverage through that member's governing authority if
12 such group health insurance coverage was available and offered
13 to the member during the member's service as a member of the
14 governing authority; and

15 (c) was participating in the group
16 health insurance program under the Retiree Health Care Act
17 prior to July 1, 1993; or

18 (d) notwithstanding the provisions of
19 Subparagraphs (b) and (c) of this paragraph, is eligible under
20 Subparagraph (a) of this paragraph and has applied before
21 August 1, 1993 to the authority to participate in the program;

22 (2) a "salaried eligible participating entity
23 governing authority member", which means a person who is not a
24 retiree and who:

25 (a) has served with salary as a member

1 of the governing authority of an employer eligible to
2 participate in the benefits of the Retiree Health Care Act;

3 (b) has maintained group health
4 insurance through that member's governing authority, if such
5 group health insurance was available and offered to the member
6 during the member's service as a member of the governing
7 authority; and

8 (c) was participating in the group
9 health insurance program under the Retiree Health Care Act
10 prior to July 1, 1993; or

11 (d) notwithstanding the provisions of
12 Subparagraphs (b) and (c) of this paragraph, is eligible under
13 Subparagraph (a) of this paragraph and has applied before
14 August 1, 1993 to the authority to participate in the program;

15 (3) an "eligible participating retiree", which
16 means a person who:

17 (a) falls within the definition of a
18 retiree, has made contributions to the fund for at least five
19 years prior to retirement and whose eligible employer during
20 that period of time made contributions as a participant in the
21 Retiree Health Care Act on the person's behalf, unless that
22 person retires on or before July 1, 1995, in which event the
23 time period required for employee and employer contributions
24 shall become the period of time between July 1, 1990 and the
25 date of retirement, and who is certified to be a retiree by the

1 educational retirement director, the executive secretary of the
2 public employees retirement ~~[board]~~ association or the
3 governing authority of an independent public employer;

4 (b) falls within the definition of a
5 retiree, retired prior to July 1, 1990 and is certified to be a
6 retiree by the educational retirement director, the executive
7 secretary of the public employees retirement association or the
8 governing authority of an independent public employer; but this
9 ~~[paragraph]~~ subparagraph does not include a retiree who was an
10 employee of an eligible employer who exercised the option not
11 to be a participating employer pursuant to the Retiree Health
12 Care Act and did not after January 1, 1993 elect to become a
13 participating employer; unless the retiree: 1) retired on or
14 before June 30, 1990; and 2) at the time of retirement did not
15 have a retirement health plan or retirement health insurance
16 coverage available from ~~[his]~~ the retiree's employer; or

17 (c) is a retiree who: 1) was at the
18 time of retirement an employee of an eligible employer who
19 exercised the option not to be a participating employer
20 pursuant to the Retiree Health Care Act, but which eligible
21 employer subsequently elected after January 1, 1993 to become a
22 participating employer; 2) has made contributions to the fund
23 for at least five years prior to retirement and whose eligible
24 employer during that period of time made contributions as a
25 participant in the Retiree Health Care Act on the person's

1 behalf, unless that person retires less than five years after
2 the date participation begins, in which event the time period
3 required for employee and employer contributions shall become
4 the period of time between the date participation begins and
5 the date of retirement; and 3) is certified to be a retiree by
6 the educational retirement director, the executive director of
7 the public employees retirement ~~[board]~~ association or the
8 governing authority of an independent public employer;

9 (4) a "legislative member", which means a
10 person who is not a retiree and who served as a member of the
11 New Mexico legislature for at least two years, but is no longer
12 a member of the legislature and is certified to be such by the
13 legislative council service; or

14 (5) a "former participating employer governing
15 authority member", which means a person, other than a
16 nonsalaried eligible participating entity governing authority
17 member or a salaried eligible participating entity governing
18 authority member, who is not a retiree and who served as a
19 member of the governing authority of a participating employer
20 for at least four years but is no longer a member of the
21 governing authority and whose length of service is certified by
22 the chief executive officer of the participating employer;

23 I. "fund" means the retiree health care fund;

24 J. "group health insurance" means coverage that
25 includes but is not limited to life insurance, accidental death

1 and dismemberment, hospital care and benefits, surgical care
2 and treatment, medical care and treatment, dental care, eye
3 care, obstetrical benefits, prescribed drugs, medicines and
4 prosthetic devices, medicare supplement, medicare carveout,
5 medicare coordination and other benefits, supplies and services
6 through the vehicles of indemnity coverages, health maintenance
7 organizations, preferred provider organizations and other
8 health care delivery systems as provided by the Retiree Health
9 Care Act and other coverages considered by the board to be
10 advisable;

11 K. "ineligible dependents" include:

12 (1) those dependents created by common law
13 relationships;

14 (2) dependents while in active military
15 service;

16 (3) parents, aunts, uncles, brothers, sisters,
17 grandchildren and other family members left in the care of an
18 eligible retiree without evidence of legal guardianship; and

19 (4) anyone not specifically referred to as an
20 eligible dependent pursuant to the rules and regulations
21 adopted by the board;

22 L. "participating employee" means an employee of
23 a participating employer, which employee has not been expelled
24 from participation in the Retiree Health Care Act pursuant to
25 Section 10-7C-10 NMSA 1978;

.159144.2

1 M. "participating employer" means an eligible
2 employer who has satisfied the conditions for participating in
3 the benefits of the Retiree Health Care Act [~~including the~~
4 ~~requirements of Subsection M of Section 10-7C-7 NMSA 1978 and~~
5 ~~Subsection D or E of Section 10-7C-9 NMSA 1978, as applicable~~];

6 N. "public entity" means a flood control authority,
7 economic development district, council of governments, regional
8 housing authority, conservancy district or other special
9 district or special purpose government; and

10 O. "retiree" means a person who:

11 (1) is receiving:

12 (a) a disability or normal retirement
13 benefit or survivor's benefit pursuant to the Educational
14 Retirement Act;

15 (b) a disability or normal retirement
16 benefit or survivor's benefit pursuant to the Public Employees
17 Retirement Act, the Judicial Retirement Act, the Magistrate
18 Retirement Act or the Public Employees Retirement Reciprocity
19 Act; or

20 (c) a disability or normal retirement
21 benefit or survivor's benefit pursuant to the retirement
22 program of an independent public employer to which that
23 employer has made periodic contributions; or

24 (2) is not receiving a survivor's benefit but
25 is the eligible dependent of a person who received a disability

1 or normal retirement benefit pursuant to the Educational
2 Retirement Act, the Public Employees Retirement Act, the
3 Judicial Retirement Act, the Magistrate Retirement Act or the
4 Public Employees Retirement Reciprocity Act."

5 Section 2. EFFECTIVE DATE.--The effective date of the
6 provisions of this act is January 1, 2007.

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47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006

INTRODUCED BY

DISCUSSION DRAFT

FOR THE PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

AN ACT

RELATING TO PRESCRIPTION DRUG COVERAGE; CHANGING THE NAME OF
THE SENIOR PRESCRIPTION DRUG PROGRAM TO THE DISCOUNT
PRESCRIPTION DRUG PROGRAM; REMOVING THE AGE REQUIREMENT;
CHANGING THE NAME OF THE SENIOR PRESCRIPTION DRUG PROGRAM FUND
TO THE DISCOUNT PRESCRIPTION DRUG PROGRAM FUND; AMENDING
SECTIONS OF THE NMSA 1978.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. Section 10-7C-17 NMSA 1978 (being Laws 2002,
Chapter 75, Section 2 and Laws 2002, Chapter 80, Section 2, as
amended) is amended to read:

"10-7C-17. CREATION OF [~~SENIOR~~] DISCOUNT PRESCRIPTION
DRUG PROGRAM.--

A. The "[~~senior~~] discount prescription drug
program" is created in the authority.

.159145.3

underscored material = new
[bracketed material] = delete

1 B. To be eligible for the [~~senior~~] discount
2 prescription drug program, a person shall [~~(1)~~] be a resident
3 of the state [~~and (2) be sixty-five years of age or older~~].

4 C. Upon a determination that the person qualifies
5 for the [~~senior~~] discount prescription drug program, the
6 authority may assess an annual administrative fee not to exceed
7 sixty dollars (\$60.00) per year. The authority shall collect
8 the fees, which shall be used by the authority to cover the
9 cost of administering the program.

10 D. The amount a qualified person pays for a
11 prescription drug shall not exceed the total cost of the
12 dispensing fee plus the contracted discounted price made
13 available to the authority for [~~this group of seniors~~] the
14 prescription drug.

15 E. The authority shall enroll and provide
16 participants with electronic or other form of membership
17 identification for use by pharmacies for each transaction.

18 F. The authority shall actively promote membership
19 and benefit information on the [~~senior~~] discount prescription
20 drug program to seniors and the general public throughout the
21 state."

22 Section 2. Section 10-7C-18 NMSA 1978 (being Laws 2002,
23 Chapter 75, Section 3 and Laws 2002, Chapter 80, Section 3) is
24 amended to read:

25 "10-7C-18. FUND CREATED.--The "[~~senior~~] discount

1 prescription drug program fund" is created in the state
2 treasury. All fees collected pursuant to Subsection C of
3 Section [~~2 of this act~~] 10-7C-17 NMSA 1978 and all rebates
4 received from drug manufacturers shall be deposited in the fund
5 and shall be used for the purposes of the [~~senior~~] discount
6 prescription drug program. Money appropriated to the fund or
7 accruing to it through rebates, gifts, grants, fees or bequests
8 shall be deposited in the fund. Earnings from investment of
9 the fund shall be credited to the fund. Money in the fund is
10 appropriated to the authority for the purpose of administering
11 the [~~senior~~] discount prescription drug program. Money in the
12 fund shall not revert at the end of any fiscal year.

13 Disbursements from the fund shall be made upon warrants drawn
14 by the secretary of finance and administration pursuant to
15 vouchers signed by the director of the authority or [~~his~~] the
16 director's authorized representative. The authority shall
17 annually adjust the enrollment fee to permit necessary
18 administration of the program but shall not exceed the amount
19 established in Subsection C of Section [~~2 of this act~~] 10-7C-17
20 NMSA 1978."

21 Section 3. Section 10-7C-19 NMSA 1978 (being Laws 2002,
22 Chapter 75, Section 4 and Laws 2002, Chapter 80, Section 4) is
23 amended to read:

24 "10-7C-19. AUDIT--FEE RECOMMENDATION.--Annually the
25 legislative finance committee shall conduct a fiscal audit of

1 the [~~senior~~] discount prescription drug program fund and the
2 administration of the program, including rebates negotiated for
3 the prescription drugs purchased by participants, and shall
4 recommend if and how much of an annual fee is necessary for
5 participants in the program."

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47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006

INTRODUCED BY

DISCUSSION DRAFT

FOR THE PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

AN ACT

RELATING TO PUBLIC SCHOOL EMPLOYEE BENEFITS; INCLUDING ALL
SCHOOL DISTRICTS IN THE STATE FOR GROUP HEALTH INSURANCE
PURPOSES; AMENDING THE PUBLIC SCHOOL INSURANCE AUTHORITY ACT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. Section 22-29-3 NMSA 1978 (being Laws 1986,
Chapter 94, Section 3, as amended) is amended to read:

"22-29-3. DEFINITIONS.--As used in the Public School
Insurance Authority Act:

A. "authority" means the public school insurance
authority;

B. "board" means the board of directors of the
public school insurance authority;

C. "charter school" means a school organized as a
charter school pursuant to the provisions of the 1999 Charter

.159146.2

1 Schools Act;

2 D. "director" means the director of the public
3 school insurance authority;

4 E. "educational entities" means state educational
5 institutions as enumerated in Article 12, Section 11 of the
6 constitution of New Mexico and other state diploma, degree-
7 granting and certificate-granting post-secondary educational
8 institutions and regional education cooperatives;

9 F. "fund" means the public school insurance fund;

10 G. "group health insurance" means coverage that
11 includes life insurance, accidental death and dismemberment,
12 medical care and treatment, dental care, eye care and other
13 coverages as determined by the authority;

14 H. "risk-related coverage" means coverage that
15 includes property and casualty, general liability, auto and
16 fleet, workers' compensation and other casualty insurance; and

17 I. "school district" means a school district as
18 defined in [~~Subsection K of~~] Section 22-1-2 NMSA 1978;
19 [~~excluding~~] however, any school district with a student
20 enrollment in excess of sixty thousand students shall be
21 included for purposes of the group health insurance coverage
22 only and is excluded from the risk-related coverage."

23 Section 2. Section 22-29-5 NMSA 1978 (being Laws 1986,
24 Chapter 94, Section 5, as amended) is amended to read:

25 "22-29-5. BOARD CREATED--MEMBERSHIP--DUTIES.--

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1 A. There is created the "board of directors of the
2 public school insurance authority". The board shall be
3 composed of [~~nine~~] at least eleven members, consisting of the
4 following:

5 (1) one member to be selected by the [~~state~~
6 ~~board of education~~] department;

7 (2) one school business official to be
8 selected by the New Mexico school administrators;

9 (3) one board member of the New Mexico school
10 boards association to be selected by the association;

11 (4) one superintendent to be selected by the
12 New Mexico superintendents' association;

13 (5) three members to be selected by the New
14 Mexico national education association and the New Mexico
15 federation of teachers with the intent that representation be
16 proportional to their respective membership, provided that each
17 of these three members be currently employed as public school
18 teachers employed by participating entities;

19 (6) one member to be selected by the board
20 from lists submitted by the participating educational entities;
21 [~~and~~]

22 (7) one member to be selected by the
23 Albuquerque public school board, but only if the Albuquerque
24 public school district participates in the authority's group
25 health insurance programs; and

1 (8) three members to be appointed by and serve
2 at the pleasure of the governor. Such members shall not be
3 employed by or on behalf of or be contracting with an employer
4 participating in or eligible to participate in the [~~public~~
5 ~~school insurance~~] authority.

6 B. Each member of the board shall serve at the
7 pleasure of the party by which [~~he~~] the member has been
8 appointed for a term not to exceed three years. Any board
9 member who has been appointed and who misses four meetings of
10 the board during a fiscal year shall be replaced and shall
11 forfeit [~~his~~] the member's position on the board, and [~~his~~] the
12 member's replacement shall be made by the organization
13 affected. The board shall set minimum terms of appointment and
14 shall elect from its membership a president, vice president and
15 secretary.

16 C. The board has the authority to hire a director
17 and appoint such other officers and employees as it may deem
18 necessary and has the authority to contract with consultants or
19 other professional persons or firms as may be necessary to
20 carry out the provisions of the Public School Insurance
21 Authority Act. The board has the authority to provide for its
22 full- and part-time employees, as it deems necessary, employee
23 benefits insurance on the same basis as a member public school
24 district may provide such employee benefits. In addition, the
25 board has the authority to provide to members of the board and

1 the employees risk coverages of the same scope and limitations
2 as are allowed its member school districts to be provided to
3 their local school boards. The board has the authority to
4 provide employees an irrevocable option of qualifying for
5 coverage under either the Educational Retirement Act or the
6 Public Employees Retirement Act.

7 D. The members of the board shall receive per diem
8 and mileage as provided in the Per Diem and Mileage Act, but
9 shall receive no other compensation, perquisite or allowance."

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47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006

INTRODUCED BY

DISCUSSION DRAFT

FOR THE PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

AN ACT

RELATING TO EMPLOYEE BENEFITS; AMENDING THE GROUP HEALTH
INSURANCE CONTRIBUTION RATES FOR THE PUBLIC SCHOOL INSURANCE
AUTHORITY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. Section 22-29-10 NMSA 1978 (being Laws 1989,
Chapter 373, Section 5, as amended) is amended to read:

"22-29-10. GROUP HEALTH INSURANCE CONTRIBUTIONS.--

A. Group health insurance contributions for school
districts, charter schools and participating entities in the
authority shall be made as follows:

~~[(1) at least seventy-five percent of the cost
of the insurance of an employee whose annual salary is less
than fifteen thousand dollars (\$15,000);~~

~~(2) at least seventy-percent of the cost of~~

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1 ~~the insurance of an employee whose annual salary is fifteen~~
2 ~~thousand dollars (\$15,000) or more but less than twenty~~
3 ~~thousand dollars (\$20,000);~~

4 ~~(3) at least sixty-five percent of the cost of~~
5 ~~the insurance of an employee whose annual salary is twenty~~
6 ~~thousand dollars (\$20,000) or more but less than twenty-five~~
7 ~~thousand dollars (\$25,000); or~~

8 ~~(4) at least sixty percent of the cost of the~~
9 ~~insurance of an employee whose annual salary is twenty-five~~
10 ~~thousand dollars (\$25,000) or more]~~

11 (1) for an employee whose annual salary is
12 less than twenty thousand dollars (\$20,000), at least eighty
13 percent of the premiums for the employee and the employee's
14 dependents;

15 (2) for an employee whose annual salary is
16 twenty thousand dollars (\$20,000) or more but less than twenty-
17 five thousand dollars (\$25,000), at least seventy-five percent
18 of the premiums for the employee and the employee's dependents;

19 (3) for an employee whose annual salary is
20 twenty-five thousand dollars (\$25,000) or more but less than
21 thirty thousand dollars (\$30,000), at least seventy percent of
22 the premiums for the employee and the employee's dependents;

23 (4) for an employee whose annual salary is
24 thirty thousand dollars (\$30,000) or more but less than one
25 hundred thousand dollars (\$100,000), at least sixty percent of

1 the premiums for the employee and the employee's dependents;
2 and

3 (5) for an employee whose annual salary is one
4 hundred thousand dollars (\$100,000) or more, at least fifty
5 percent of the premiums for the employee and the employee's
6 dependents.

7 B. Within available revenue, school districts,
8 charter schools and participating entities in the authority may
9 contribute ~~[up to eighty percent of the cost of the insurance~~
10 ~~of all employees]~~ no more than the following for group health
11 insurance:

12 (1) for an employee whose annual salary is
13 less than twenty thousand dollars (\$20,000), no more than
14 ninety percent of the premiums for the employee and the
15 employee's dependents;

16 (2) for an employee whose annual salary is
17 twenty thousand dollars (\$20,000) or more but less than twenty-
18 five thousand dollars (\$25,000), no more than eighty-five
19 percent of the premiums for the employee and the employee's
20 dependents;

21 (3) for an employee whose annual salary is
22 twenty-five thousand dollars (\$25,000) or more but less than
23 thirty thousand dollars (\$30,000), no more than eighty percent
24 of the premiums for the employee and the employee's dependents;

25 (4) for an employee whose annual salary is

1 thirty thousand dollars (\$30,000) or more but less than one
2 hundred thousand dollars (\$100,000), no more than seventy
3 percent of the premiums for the employee and the employee's
4 dependents; and

5 (5) for an employee whose annual salary is one
6 hundred thousand dollars (\$100,000) or more, no more than sixty
7 percent of the premiums for the employee and the employee's
8 dependents.

9 C. Whenever a school district, charter school or
10 participating entity in the authority offers to its employees
11 alternative health plan benefit options, including health
12 maintenance organizations, preferred provider organizations or
13 panel doctor plans, the school district, charter school or
14 participating entity may pay an amount on behalf of the
15 employee and family member for the indemnity health insurance
16 plan sufficient to result in equal employee monthly costs to
17 the cost of the health maintenance organization plans,
18 preferred provider organization plans or panel doctor plans,
19 regardless of the percentage limitations in the Public School
20 Insurance Authority Act. School districts, charter schools and
21 participating entities in the authority may pay up to one
22 hundred percent of the first fifty thousand dollars (\$50,000)
23 of term life insurance."

24 Section 2. EFFECTIVE DATE.--The effective date of the
25 provisions of this act is October 1, 2006.

BILL

47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006

INTRODUCED BY

DISCUSSION DRAFT

FOR THE PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE

AN ACT

RELATING TO THE LEGISLATURE; CREATING A JOINT INTERIM COMMITTEE
FOR THE OVERSIGHT OF PUBLIC EMPLOYEE BENEFITS PROGRAMS AND
FUNDS; MAKING AN APPROPRIATION; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. PUBLIC EMPLOYEE BENEFITS OVERSIGHT COMMITTEE
CREATED.--There is created a joint interim legislative
committee that shall be known as the "public employee benefits
oversight committee". The committee shall function from the
date of its appointment until the first day of December prior
to the first session of the forty-ninth legislature.

Section 2. MEMBERSHIP--APPOINTMENT--VACANCIES.--

A. The public employee benefits oversight committee
shall be composed of six members. Three members of the house
of representatives shall be appointed by the speaker of the

.159149.2

1 house of representatives and three members of the senate shall
2 be appointed by the committees' committee of the senate or, if
3 the appointments are made in the interim, by the president pro
4 tempore of the senate after consultation with and agreement of
5 a majority of the members of the committees' committee.

6 B. Members of the public employee benefits
7 oversight committee shall be appointed from each house so as to
8 give the two major political parties in each house the same
9 proportional representation on the committee as prevails in
10 each house; however, in no event shall either party have less
11 than one member from each house on the committee. Vacancies on
12 the committee shall be filled by appointment in the same manner
13 as the original appointments. The chair and vice chair of the
14 committee shall be appointed by the New Mexico legislative
15 council to serve for one interim. Appointments to the position
16 of chair shall alternate on an annual basis between the house
17 of representatives and the senate. The position of vice chair
18 shall always be from the chamber that does not hold the
19 position of chair.

20 C. No action shall be taken by the committee if a
21 majority of the total membership from either house on the
22 committee rejects such action.

23 Section 3. DUTIES.--

24 A. After its appointment, the public employee
25 benefits oversight committee shall hold one organizational

1 meeting to develop a work plan and budget for the ensuing
2 interim.

3 B. In developing the work plan, the public employee
4 benefits oversight committee shall take into consideration the
5 public interest in ensuring that the benefits programs
6 administered by the retiree health care authority, the public
7 school insurance authority, Albuquerque public schools and the
8 state group benefits program are financially sound and are
9 efficiently providing adequate benefits to their members'
10 employees or retirees and their dependents. The committee
11 shall also review the status of funds and practices of
12 unemployment insurance, workers' compensation, public employees
13 retirement and educational retirement programs.

14 C. The public employee benefits oversight committee
15 shall solicit public input.

16 D. The work plan and budget shall be submitted to
17 the New Mexico legislative council for approval. Upon approval
18 of the work plan and budget by the council, the public employee
19 benefits oversight committee shall examine:

20 (1) the statutes, constitutional provisions,
21 regulations and court decisions governing the benefits plans
22 provided by the retiree health care authority, the public
23 school insurance authority, the state group benefits program,
24 the workers' compensation administration, the public employees
25 retirement association and the educational retirement board and

1 the administration and delivery of unemployment insurance;

2 (2) the actuarial health of the funds
3 supporting the programs, the present and future costs of
4 maintaining the programs, the extent of any forecasted funding
5 deficit or surplus and the extent to which the legislature is
6 responsible for funding the programs, the reserves or
7 administration of the programs;

8 (3) the adequacy of the plans, policies,
9 delivery of services and administration; and

10 (4) with regard to the public employee,
11 educational employee and retiree benefit programs, whether
12 greater coordination and delivery of benefit plans with
13 increased similarity of components would provide greater
14 economies for employers and employees and in administration of
15 the programs.

16 Section 4. SUBCOMMITTEES.-- Subcommittees shall be
17 created only by majority vote of all members appointed to the
18 public employee benefits oversight committee and with the prior
19 approval of the New Mexico legislative council. A subcommittee
20 shall be composed of at least one member from the senate and
21 one member from the house of representatives, and at least one
22 member of the minority party shall be a member of the
23 subcommittee. All meetings and expenditures of a subcommittee
24 shall be approved by the full committee in advance of such
25 meeting or expenditure, and the approval shall be shown in the

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1 minutes of the committee.

2 Section 5. REPORT.--The public employee benefits
3 oversight committee shall make a report of its findings and
4 recommendations for the consideration of the legislature. The
5 report and suggested legislation shall be made available to the
6 New Mexico legislative council by December 15 of each interim.

7 Section 6. STAFF.--The staff for the public employee
8 benefits oversight committee shall be provided by the
9 legislative council service.

10 Section 7. APPROPRIATION.--Fifty thousand dollars
11 (\$50,000) is appropriated from legislative cash balances to the
12 legislative council service for expenditure in fiscal years
13 2006 and 2007 to pay for technical and legal assistance and for
14 necessary equipment and supplies used in carrying out the
15 provisions of this act and for reimbursing the per diem and
16 mileage expenses of the committee. Any unexpended or
17 unencumbered balance remaining at the end of fiscal year 2007
18 shall revert to legislative cash balances. Payments from the
19 appropriation shall be made upon vouchers signed by the
20 director of the legislative council service or the director's
21 authorized representative.

22 Section 8. EMERGENCY.--It is necessary for the public
23 peace, health and safety that this act take effect immediately.